EXHIBIT A

7.6.18 1:00

SUMMONS
(CITACION JUDICIAL)

SUM-100

NOTICE TO DEFENDANT: HEALTH NET OF CALIFORNIA, INC. a California corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation, MANAGED HEALTH NETWORK, INC., a Delaware corporation; HEALTH NET, INC., a Delaware corporation; and CENTENE CORPORATION, a Delaware corporation, and DOES 1 through 100, inclusive
(AVISO AL DEMANDADO):

YOU ARE BEING SUED BY PLAINTIFF: OHAD BARKAN, individually and on behalf of all others similarly situated
(LO ESTÁ DEMANDANDO EL DEMANDANTE):

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)

CONFORMED COPY
ORIGINAL FILED
Superior Court of California
County of Los Angeles

JUN 29 2018

Sherri R. Carter, Executive Officer/Clerk
By: Brittny Smith, Deputy
Brittny Smith

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.
¡AVISO! Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.

Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (www.sucorte.ca.gov), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.

Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (www.lawhelpcalifornia.org), en el Centro de Ayuda de las Cortes de California, (www.sucorte.ca.gov) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.

The name and address of the court is:
(El nombre y dirección de la corte es):
SUPERIOR COURT OF CALIFORNIA
111 N. Hill Street
Los Angeles, CA 90012

CASE NUMBER:
(Número del Caso): BC711987

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):
Richard T. Collins (166577)
Damon D. Eisenbrey (215927)
CALLAHAN & BLAINE
Santa Ana, CA 92707
714-241-4444 714-241-4445

DATE: JUN 29 2018 Clerk, by Brittny Smith, Deputy
(Fecha) SHERRI R. CARTER *(Secretario)* *(Adjunto)*

(For proof of service of this summons, use Proof of Service of Summons (form POS-010).)
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, (POS-010)).

[SEAL]

NOTICE TO THE PERSON SERVED: You are served
1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify)*:
3. ☒ on behalf of *(specify)*: Health Net, Inc, a Delaware corporation
under: ☒ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
☐ other *(specify)*:
4. ☐ by personal delivery on *(date)*:

Page 1 of 1

COPY

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
Richard T. Collins (166577)
Damon D. Eisenbrey (215927)
CALLAHAN & BLAINE
3 Hutton Centre Drive, Ninth Fl.
Santa Ana, CA 92707
TELEPHONE NO.: 714-241-4444 FAX NO.: 714-241-4445
ATTORNEY FOR (Name): Plaintiff, Ohan Barkan

FOR COURT USE ONLY

CONFORMED COPY
ORIGINAL FILED
Superior Court of California
County of Los Angeles

JUN 29 2018

Sherri R. Carter, Executive Officer/Clerk
By: Bethany Smith, Deputy
Bethany Smith

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES
STREET ADDRESS: 111 N. Hill Street
MAILING ADDRESS:
CITY AND ZIP CODE: Los Angeles, CA 90012
BRANCH NAME: STANLEY MOSK COURTHOUSE

CASE NAME: Barkan v. Health Net of California, Inc.

CASE NUMBER: BC711987

JUDGE:

DEPT:

CIVIL CASE COVER SHEET
[X] Unlimited (Amount demanded exceeds $25,000) [ ] Limited (Amount demanded is $25,000 or less)

Complex Case Designation
[ ] Counter [ ] Joinder
Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)

Items 1-6 below must be completed (see instructions on page 2).

1. Check one box below for the case type that best describes this case:

Auto Tort
- [ ] Auto (22)
- [ ] Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- [ ] Asbestos (04)
- [ ] Product liability (24)
- [ ] Medical malpractice (45)
- [ ] Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- [ ] Business tort/unfair business practice (07)
- [ ] Civil rights (08)
- [ ] Defamation (13)
- [ ] Fraud (16)
- [ ] Intellectual property (19)
- [ ] Professional negligence (25)
- [ ] Other non-PI/PD/WD tort (35)

Employment
- [ ] Wrongful termination (36)
- [ ] Other employment (15)

Contract
- [ ] Breach of contract/warranty (06)
- [ ] Rule 3.740 collections (09)
- [ ] Other collections (09)
- [ ] Insurance coverage (18)
- [ ] Other contract (37)

Real Property
- [ ] Eminent domain/inverse condemnation (14)
- [ ] Wrongful eviction (33)
- [ ] Other real property (26)

Unlawful Detainer
- [ ] Commercial (31)
- [ ] Residential (32)
- [ ] Drugs (38)

Judicial Review
- [ ] Asset forfeiture (05)
- [ ] Petition re: arbitration award (11)
- [ ] Writ of mandate (02)
- [ ] Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400-3.403)
- [ ] Antitrust/Trade regulation (03)
- [ ] Construction defect (10)
- [ ] Mass tort (40)
- [ ] Securities litigation (28)
- [ ] Environmental/Toxic tort (30)
- [X] Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- [ ] Enforcement of judgment (20)

Miscellaneous Civil Complaint
- [ ] RICO (27)
- [ ] Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- [ ] Partnership and corporate governance (21)
- [ ] Other petition *(not specified above)* (43)

2. This case [X] is [ ] is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. [ ] Large number of separately represented parties
   b. [X] Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. [X] Substantial amount of documentary evidence
   d. [X] Large number of witnesses
   e. [ ] Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. [X] Substantial postjudgment judicial supervision
3. Remedies sought *(check all that apply)*: a. [X] monetary b. [X] nonmonetary; declaratory or injunctive relief c. [X] punitive
4. Number of causes of action *(specify)*: Five
5. This case [X] is [ ] is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

Date: June 29, 2018
Richard T. Collins
(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE
- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on all other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

Form Adopted for Mandatory Use
Judicial Council of California
CM-010 [Rev. July 1, 2007]

CIVIL CASE COVER SHEET

Cal. Rules of Court, rules 2.30, 3.220, 3.400-3.403, 3.740;
Cal. Standards of Judicial Administration, std. 3.10

INSTRUCTIONS ON HOW TO COMPLETE THE COVER SHEET

CM-010

To Plaintiffs and Others Filing First Papers. If you are filing a first paper (for example, a complaint) in a civil case, you must complete and file, along with your first paper, the *Civil Case Cover Sheet* contained on page 1. This information will be used to compile statistics about the types and numbers of cases filed. You must complete items 1 through 6 on the sheet. In item 1, you must check one box for the case type that best describes the case. If the case fits both a general and a more specific type of case listed in item 1, check the more specific one. If the case has multiple causes of action, check the box that best indicates the primary cause of action. To assist you in completing the sheet, examples of the cases that belong under each case type in item 1 are provided below. A cover sheet must be filed only with your initial paper. Failure to file a cover sheet with the first paper filed in a civil case may subject a party, its counsel, or both to sanctions under rules 2.30 and 3.220 of the California Rules of Court.

To Parties in Rule 3.740 Collections Cases. A "collections case" under rule 3.740 is defined as an action for recovery of money owed in a sum stated to be certain that is not more than $25,000, exclusive of interest and attorney's fees, arising from a transaction in which property, services, or money was acquired on credit. A collections case does not include an action seeking the following: (1) tort damages, (2) punitive damages, (3) recovery of real property, (4) recovery of personal property, or (5) a prejudgment writ of attachment. The identification of a case as a rule 3.740 collections case on this form means that it will be exempt from the general time-for-service requirements and case management rules, unless a defendant files a responsive pleading. A rule 3.740 collections case will be subject to the requirements for service and obtaining a judgment in rule 3.740.

To Parties in Complex Cases. In complex cases only, parties must also use the *Civil Case Cover Sheet* to designate whether the case is complex. If a plaintiff believes the case is complex under rule 3.400 of the California Rules of Court, this must be indicated by completing the appropriate boxes in items 1 and 2. If a plaintiff designates a case as complex, the cover sheet must be served with the complaint on all parties to the action. A defendant may file and serve no later than the time of its first appearance a joinder in the plaintiff's designation, a counter-designation that the case is not complex, or, if the plaintiff has made no designation, a designation that the case is complex.

CASE TYPES AND EXAMPLES

Auto Tort
- Auto (22)—Personal Injury/Property Damage/Wrongful Death
- Uninsured Motorist (46) (*if the case involves an uninsured motorist claim subject to arbitration, check this item instead of Auto*)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- Asbestos (04)
  - Asbestos Property Damage
  - Asbestos Personal Injury/Wrongful Death
- Product Liability (*not asbestos or toxic/environmental*) (24)
- Medical Malpractice (45)
  - Medical Malpractice—Physicians & Surgeons
  - Other Professional Health Care Malpractice
- Other PI/PD/WD (23)
  - Premises Liability (e.g., slip and fall)
  - Intentional Bodily Injury/PD/WD (e.g., assault, vandalism)
  - Intentional Infliction of Emotional Distress
  - Negligent Infliction of Emotional Distress
  - Other PI/PD/WD

Non-PI/PD/WD (Other) Tort
- Business Tort/Unfair Business Practice (07)
- Civil Rights (e.g., discrimination, false arrest) (*not civil harassment*) (08)
- Defamation (e.g., slander, libel) (13)
- Fraud (16)
- Intellectual Property (19)
- Professional Negligence (25)
  - Legal Malpractice
  - Other Professional Malpractice (*not medical or legal*)
- Other Non-PI/PD/WD Tort (35)

Employment
- Wrongful Termination (36)
- Other Employment (15)

Contract
- Breach of Contract/Warranty (06)
  - Breach of Rental/Lease Contract (*not unlawful detainer or wrongful eviction*)
  - Contract/Warranty Breach—Seller Plaintiff (*not fraud or negligence*)
  - Negligent Breach of Contract/Warranty
  - Other Breach of Contract/Warranty
- Collections (e.g., money owed, open book accounts) (09)
  - Collection Case—Seller Plaintiff
  - Other Promissory Note/Collections Case
- Insurance Coverage (*not provisionally complex*) (18)
  - Auto Subrogation
  - Other Coverage
- Other Contract (37)
  - Contractual Fraud
  - Other Contract Dispute

Real Property
- Eminent Domain/Inverse Condemnation (14)
- Wrongful Eviction (33)
- Other Real Property (e.g., quiet title) (26)
  - Writ of Possession of Real Property
  - Mortgage Foreclosure
  - Quiet Title
  - Other Real Property (*not eminent domain, landlord/tenant, or foreclosure*)

Unlawful Detainer
- Commercial (31)
- Residential (32)
- Drugs (38) (*if the case involves illegal drugs, check this item; otherwise, report as Commercial or Residential*)

Judicial Review
- Asset Forfeiture (05)
- Petition Re: Arbitration Award (11)
- Writ of Mandate (02)
  - Writ–Administrative Mandamus
  - Writ–Mandamus on Limited Court Case Matter
  - Writ–Other Limited Court Case Review
- Other Judicial Review (39)
  - Review of Health Officer Order
  - Notice of Appeal–Labor Commissioner Appeals

Provisionally Complex Civil Litigation (Cal. Rules of Court Rules 3.400–3.403)
- Antitrust/Trade Regulation (03)
- Construction Defect (10)
- Claims Involving Mass Tort (40)
- Securities Litigation (28)
- Environmental/Toxic Tort (30)
- Insurance Coverage Claims (*arising from provisionally complex case type listed above*) (41)

Enforcement of Judgment
- Enforcement of Judgment (20)
  - Abstract of Judgment (Out of County)
  - Confession of Judgment (*non-domestic relations*)
  - Sister State Judgment
  - Administrative Agency Award (*not unpaid taxes*)
  - Petition/Certification of Entry of Judgment on Unpaid Taxes
  - Other Enforcement of Judgment Case

Miscellaneous Civil Complaint
- RICO (27)
- Other Complaint (*not specified above*) (42)
  - Declaratory Relief Only
  - Injunctive Relief Only (*non-harassment*)
  - Mechanics Lien
  - Other Commercial Complaint Case (*non-tort/non-complex*)
  - Other Civil Complaint (*non-tort/non-complex*)

Miscellaneous Civil Petition
- Partnership and Corporate Governance (21)
- Other Petition (*not specified above*) (43)
  - Civil Harassment
  - Workplace Violence
  - Elder/Dependent Adult Abuse
  - Election Contest
  - Petition for Name Change
  - Petition for Relief from Late Claim
  - Other Civil Petition

SHORT TITLE: Barkan v. Health Net of California, Inc.	CASE NUMBER BC711987

CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION (CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)

This form is required pursuant to Local Rule 2.3 in all new civil case filings in the Los Angeles Superior Court.

Step 1: After completing the Civil Case Cover Sheet (Judicial Council form CM-010), find the exact case type in Column A that corresponds to the case type indicated in the Civil Case Cover Sheet.

Step 2: In Column B, check the box for the type of action that best describes the nature of the case.

Step 3: In Column C, circle the number which explains the reason for the court filing location you have chosen.

Applicable Reasons for Choosing Court Filing Location (Column C)

1. Class actions must be filed in the Stanley Mosk Courthouse, Central District.
2. Permissive filing in central district.
3. Location where cause of action arose.
4. Mandatory personal injury filing in North District.
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside.
10. Location of Labor Commissioner Office.
11. Mandatory filing location (Hub Cases – unlawful detainer, limited non-collection, limited collection, or personal injury).

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons – See Step 3 Above
Auto Tort	Auto (22)	☐ A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1, 4, 11
	Uninsured Motorist (46)	☐ A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1, 4, 11
Other Personal Injury/ Property Damage/ Wrongful Death Tort	Asbestos (04)	☐ A6070 Asbestos Property Damage ☐ A7221 Asbestos - Personal Injury/Wrongful Death	1, 11 1, 11
	Product Liability (24)	☐ A7260 Product Liability (not asbestos or toxic/environmental)	1, 4, 11
	Medical Malpractice (45)	☐ A7210 Medical Malpractice - Physicians & Surgeons ☐ A7240 Other Professional Health Care Malpractice	1, 4, 11 1, 4, 11
	Other Personal Injury Property Damage Wrongful Death (23)	☐ A7250 Premises Liability (e.g., slip and fall) ☐ A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.) ☐ A7270 Intentional Infliction of Emotional Distress ☐ A7220 Other Personal Injury/Property Damage/Wrongful Death	1, 4, 11 1, 4, 11 1, 4, 11 1, 4, 11

SHORT TITLE: Barkan v. Health Net of California, Inc.	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Non-Personal Injury/ Property Damage/ Wrongful Death Tort	Business Tort (07)	☐ A6029 Other Commercial/Business Tort (not fraud/breach of contract)	1, 2, 3
	Civil Rights (08)	☐ A6005 Civil Rights/Discrimination	1, 2, 3
	Defamation (13)	☐ A6010 Defamation (slander/libel)	1, 2, 3
	Fraud (16)	☐ A6013 Fraud (no contract)	1, 2, 3
	Professional Negligence (25)	☐ A6017 Legal Malpractice ☐ A6050 Other Professional Malpractice (not medical or legal)	1, 2, 3 1, 2, 3
	Other (35)	☐ A6025 Other Non-Personal Injury/Property Damage tort	1, 2, 3
Employment	Wrongful Termination (36)	☐ A6037 Wrongful Termination	1, 2, 3
	Other Employment (15)	☐ A6024 Other Employment Complaint Case ☐ A6109 Labor Commissioner Appeals	1, 2, 3 10
Contract	Breach of Contract/ Warranty (06) (not insurance)	☐ A6004 Breach of Rental/Lease Contract (not unlawful detainer or wrongful eviction) ☐ A6008 Contract/Warranty Breach -Seller Plaintiff (no fraud/negligence) ☐ A6019 Negligent Breach of Contract/Warranty (no fraud) ☐ A6028 Other Breach of Contract/Warranty (not fraud or negligence)	2, 5 2, 5 1, 2, 5 1, 2, 5
	Collections (09)	☐ A6002 Collections Case-Seller Plaintiff ☐ A6012 Other Promissory Note/Collections Case ☐ A6034 Collections Case-Purchased Debt (Charged Off Consumer Debt Purchased on or after January 1, 2014)	5, 6, 11 5, 11 5, 6, 11
	Insurance Coverage (18)	☐ A6015 Insurance Coverage (not complex)	1, 2, 5, 8
	Other Contract (37)	☐ A6009 Contractual Fraud ☐ A6031 Tortious Interference ☐ A6027 Other Contract Dispute(not breach/insurance/fraud/negligence)	1, 2, 3, 5 1, 2, 3, 5 1, 2, 3, 8, 9
Real Property	Eminent Domain/Inverse Condemnation (14)	☐ A7300 Eminent Domain/Condemnation Number of parcels _____	2, 6
	Wrongful Eviction (33)	☐ A6023 Wrongful Eviction Case	2, 6
	Other Real Property (26)	☐ A6018 Mortgage Foreclosure ☐ A6032 Quiet Title ☐ A6060 Other Real Property (not eminent domain, landlord/tenant, foreclosure)	2, 6 2, 6 2, 6
Unlawful Detainer	Unlawful Detainer-Commercial (31)	☐ A6021 Unlawful Detainer-Commercial (not drugs or wrongful eviction)	6, 11
	Unlawful Detainer-Residential (32)	☐ A6020 Unlawful Detainer-Residential (not drugs or wrongful eviction)	6, 11
	Unlawful Detainer-Post-Foreclosure (34)	☐ A6020F Unlawful Detainer-Post-Foreclosure	2, 6, 11
	Unlawful Detainer-Drugs (38)	☐ A6022 Unlawful Detainer-Drugs	2, 6, 11

SHORT TITLE: Barkan v. Health Net of California, Inc.	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Judicial Review	Asset Forfeiture (05)	☐ A6108 Asset Forfeiture Case	2, 3, 6
	Petition re Arbitration (11)	☐ A6115 Petition to Compel/Confirm/Vacate Arbitration	2, 6
	Writ of Mandate (02)	☐ A6151 Writ - Administrative Mandamus	2, 8
		☐ A6152 Writ - Mandamus on Limited Court Case Matter	2
		☐ A6153 Writ - Other Limited Court Case Review	2
	Other Judicial Review (39)	☐ A6150 Other Writ /Judicial Review	2, 8
Provisionally Complex Litigation	Antitrust/Trade Regulation (03)	☐ A6003 Antitrust/Trade Regulation	1, 2, 8
	Construction Defect (10)	☐ A6007 Construction Defect	1, 2, 3
	Claims Involving Mass Tort (40)	☐ A6006 Claims Involving Mass Tort	1, 2, 8
	Securities Litigation (28)	☐ A6035 Securities Litigation Case	1, 2, 8
	Toxic Tort Environmental (30)	☐ A6036 Toxic Tort/Environmental	1, 2, 3, 8
	Insurance Coverage Claims from Complex Case (41)	☒ A6014 Insurance Coverage/Subrogation (complex case only)	1, 2, 5, 8
Enforcement of Judgment	Enforcement of Judgment (20)	☐ A6141 Sister State Judgment	2, 5, 11
		☐ A6160 Abstract of Judgment	2, 6
		☐ A6107 Confession of Judgment (non-domestic relations)	2, 9
		☐ A6140 Administrative Agency Award (not unpaid taxes)	2, 8
		☐ A6114 Petition/Certificate for Entry of Judgment on Unpaid Tax	2, 8
		☐ A6112 Other Enforcement of Judgment Case	2, 8, 9
Miscellaneous Civil Complaints	RICO (27)	☐ A6033 Racketeering (RICO) Case	1, 2, 8
	Other Complaints (Not Specified Above) (42)	☐ A6030 Declaratory Relief Only	1, 2, 8
		☐ A6040 Injunctive Relief Only (not domestic/harassment)	2, 8
		☐ A6011 Other Commercial Complaint Case (non-tort/non-complex)	1, 2, 8
		☐ A6000 Other Civil Complaint (non-tort/non-complex)	1, 2, 8
	Partnership Corporation Governance (21)	☐ A6113 Partnership and Corporate Governance Case	2, 8
Miscellaneous Civil Petitions	Other Petitions (Not Specified Above) (43)	☐ A6121 Civil Harassment	2, 3, 9
		☐ A6123 Workplace Harassment	2, 3, 9
		☐ A6124 Elder/Dependent Adult Abuse Case	2, 3, 9
		☐ A6190 Election Contest	2
		☐ A6110 Petition for Change of Name/Change of Gender	2, 7
		☐ A6170 Petition for Relief from Late Claim Law	2, 3, 8
		☐ A6100 Other Civil Petition	2, 9

SHORT TITLE: Barkan v. Health Net of California, Inc.	CASE NUMBER

Step 4: Statement of Reason and Address: Check the appropriate boxes for the numbers shown under Column C for the type of action that you have selected. Enter the address which is the basis for the filing location, including zip code. (No address required for class action cases).

REASON:	ADDRESS:		
[X] 1. [ ] 2. [ ] 3. [ ] 4. [ ] 5. [ ] 6. [ ] 7. [ ] 8. [ ] 9. [ ] 10. [ ] 11.			
CITY:	STATE:	ZIP CODE:	
Los Angeles	CA	90012	

Step 5: Certification of Assignment: I certify that this case is properly filed in the Los Angeles District of the Superior Court of California, County of Los Angeles [Code Civ. Proc., §392 et seq., and Local Rule 2.3(a)(1)(E)].

Dated: June 29, 2018

(SIGNATURE OF ATTORNEY/FILING PARTY)
Richard T. Collins

PLEASE HAVE THE FOLLOWING ITEMS COMPLETED AND READY TO BE FILED IN ORDER TO PROPERLY COMMENCE YOUR NEW COURT CASE:

1. Original Complaint or Petition.
2. If filing a Complaint, a completed Summons form for issuance by the Clerk.
3. Civil Case Cover Sheet, Judicial Council form CM-010.
4. Civil Case Cover Sheet Addendum and Statement of Location form, LACIV 109, LASC Approved 03-04 (Rev. 02/16).
5. Payment in full of the filing fee, unless there is court order for waiver, partial or scheduled payments.
6. A signed order appointing the Guardian ad Litem, Judicial Council form CIV-010, if the plaintiff or petitioner is a minor under 18 years of age will be required by Court in order to issue a summons.
7. Additional copies of documents to be conformed by the Clerk. Copies of the cover sheet and this addendum must be served along with the summons and complaint, or other initiating pleading in the case.

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES
NOTICE OF CASE ASSIGNMENT - UNLIMITED CIVIL – CLASS ACTION/COMPLEX
312 N. SPRING STREET COURTHOUSE

Case Number BC711987

THIS FORM IS TO BE SERVED WITH THE SUMMONS AND COMPLAINT

Your case is assigned for all purposes to the judicial officer indicated below.

	ASSIGNED JUDGE	DEPT	ROOM
	Hon. Elihu M. Berle	6	211
	Hon. William F. Highberger	10	10
	Hon. John Shepard Wiley, Jr.	9	9
u	Hon. Kenneth Freeman	14	14
	Hon. Ann Jones	11	11
	Hon. Maren E. Nelson	17	17
	Hon. Carolyn B. Kuhl	12	12

	ASSIGNED JUDGE	DEPT	ROOM
	Hon. Brian S. Currey	15	15
	*Provisional complex (non-class action) case assignment pending complex determination	14	Supervising Judge 14

Given to the Plaintiff/Cross-Complainant/Attorney of Record on JUN 29 2018 (Date)

SHERRI R. CARTER, Executive Officer/Clerk of Court

By _____, Deputy Clerk

INSTRUCTIONS FOR HANDLING UNLIMITED CIVIL CASES

The following critical provisions of the California Rules of Court, Title 3, Division 7, as applicable in the Superior Court, are summarized for your assistance.

APPLICATION
The Division 7 Rules were effective January 1, 2007. They apply to all general civil cases.

PRIORITY OVER OTHER RULES
The Division 7 Rules shall have priority over all other Local Rules to the extent the others are inconsistent.

CHALLENGE TO ASSIGNED JUDGE
A challenge under Code of Civil Procedure Section 170.6 must be made within 15 days after notice of assignment for all purposes to a judge, or if a party has not yet appeared, within 15 days of the first appearance.

TIME STANDARDS
Cases assigned to the Independent Calendaring Courts will be subject to processing under the following time standards:

COMPLAINTS
All complaints shall be served within 60 days of filing and proof of service shall be filed within 90 days.

CROSS-COMPLAINTS
Without leave of court first being obtained, no cross-complaint may be filed by any party after their answer is filed. Cross-complaints shall be served within 30 days of the filing date and a proof of service filed within 60 days of the filing date.

STATUS CONFERENCE
A status conference will be scheduled by the assigned Independent Calendar Judge no later than 270 days after the filing of the complaint. Counsel must be fully prepared to discuss the following issues: alternative dispute resolution, bifurcation, settlement, trial date, and expert witnesses.

FINAL STATUS CONFERENCE
The Court will require the parties to attend a final status conference not more than 10 days before the scheduled trial date. All parties shall have motions in limine, bifurcation motions, statements of major evidentiary issues, dispositive motions, requested form jury instructions, special jury instructions, and special jury verdicts timely filed and served prior to the conference. These matters may be heard and resolved at this conference. At least five days before this conference, counsel must also have exchanged lists of exhibits and witnesses, and have submitted to the court a brief statement of the case to be read to the jury panel as required by Chapter Three of the Los Angeles Superior Court Rules.

SANCTIONS
The court will impose appropriate sanctions for the failure or refusal to comply with Chapter Three Rules, orders made by the Court, and time standards or deadlines established by the Court or by the Chapter Three Rules. Such sanctions may be on a party, or if appropriate, on counsel for a party.

This is not a complete delineation of the Division 7 or Chapter Three Rules, and adherence only to the above provisions is therefore not a guarantee against the imposition of sanctions under Trial Court Delay Reduction. Careful reading and compliance with the actual Chapter Rules is imperative.

Class Actions
Pursuant to Local Rule 2.3, all class actions shall be filed at the Stanley Mosk Courthouse and are randomly assigned to a complex judge at the designated complex courthouse. If the case is found not to be a class action it will be returned to an Independent Calendar Courtroom for all purposes.

***Provisionally Complex Cases**
Cases filed as provisionally complex are initially assigned to the Supervising Judge of complex litigation for determination of complex status. If the case is deemed to be complex within the meaning of California Rules of Court 3.400 et seq., it will be randomly assigned to a complex judge at the designated complex courthouse. If the case is found not to be complex, it will be returned to an Independent Calendar Courtroom for all purposes.

VOLUNTARY EFFICIENT LITIGATION STIPULATIONS

Superior Court of California
County of Los Angeles

Los Angeles County
Bar Association
Litigation Section

Los Angeles County
Bar Association Labor and
Employment Law Section

Consumer Attorneys
Association of Los Angeles

Southern California
Defense Counsel

Association of
Business Trial Lawyers

California Employment
Lawyers Association

The Early Organizational Meeting Stipulation, Discovery Resolution Stipulation, and Motions in Limine Stipulation are voluntary stipulations entered into by the parties. The parties may enter into one, two, or all three of the stipulations; however, they may not alter the stipulations as written, because the Court wants to ensure uniformity of application. These stipulations are meant to encourage cooperation between the parties and to assist in resolving issues in a manner that promotes economic case resolution and judicial efficiency.

The following organizations endorse the goal of promoting efficiency in litigation and ask that counsel consider using these stipulations as a voluntary way to promote communications and procedures among counsel and with the court to fairly resolve issues in their cases.

◆Los Angeles County Bar Association Litigation Section◆

◆ Los Angeles County Bar Association Labor and Employment Law Section◆

◆Consumer Attorneys Association of Los Angeles◆

◆Southern California Defense Counsel◆

◆Association of Business Trial Lawyers◆

◆California Employment Lawyers Association◆

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY:	STATE BAR NUMBER	Reserved for Clerk's File Stamp
TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES		
COURTHOUSE ADDRESS:		
PLAINTIFF:		
DEFENDANT:		
STIPULATION – EARLY ORGANIZATIONAL MEETING		CASE NUMBER:

This stipulation is intended to encourage cooperation among the parties at an early stage in the litigation and to assist the parties in efficient case resolution.

The parties agree that:

1. The parties commit to conduct an initial conference (in-person or via teleconference or via videoconference) within 15 days from the date this stipulation is signed, *to discuss and consider whether there can be agreement on the following*:

   a. Are motions to challenge the pleadings necessary? If the issue can be resolved by amendment as of right, or if the Court would allow leave to amend, could an amended complaint resolve most or all of the issues a demurrer might otherwise raise? If so, the parties agree to work through pleading issues so that a demurrer need only raise issues they cannot resolve. Is the issue that the defendant seeks to raise amenable to resolution on demurrer, or would some other type of motion be preferable? Could a voluntary targeted exchange of documents or information by any party cure an uncertainty in the pleadings?

   b. Initial mutual exchanges of documents at the "core" of the litigation. (For example, in an employment case, the employment records, personnel file and documents relating to the conduct in question could be considered "core." In a personal injury case, an incident or police report, medical records, and repair or maintenance records could be considered "core.");

   c. Exchange of names and contact information of witnesses;

   d. Any insurance agreement that may be available to satisfy part or all of a judgment, or to indemnify or reimburse for payments made to satisfy a judgment;

   e. Exchange of any other information that might be helpful to facilitate understanding, handling, or resolution of the case in a manner that preserves objections or privileges by agreement;

   f. Controlling issues of law that, if resolved early, will promote efficiency and economy in other phases of the case. Also, when and how such issues can be presented to the Court;

   g. Whether or when the case should be scheduled with a settlement officer, what discovery or court ruling on legal issues is reasonably required to make settlement discussions meaningful, and whether the parties wish to use a sitting judge or a private mediator or other options as

SHORT TITLE:	CASE NUMBER

discussed in the "Alternative Dispute Resolution (ADR) Information Package" served with the complaint;

h. Computation of damages, including documents, not privileged or protected from disclosure, on which such computation is based;

i. Whether the case is suitable for the Expedited Jury Trial procedures (see information at www.lacourt.org under "*Civil*" and then under "*General Information*").

2. The time for a defending party to respond to a complaint or cross-complaint will be extended to _____ (INSERT DATE) for the complaint, and _____ (INSERT DATE) for the cross-complaint, which is comprised of the 30 days to respond under Government Code § 68616(b), and the 30 days permitted by Code of Civil Procedure section 1054(a), good cause having been found by the Civil Supervising Judge due to the case management benefits provided by this Stipulation. A copy of the General Order can be found at www.lacourt.org under "*Civil*", click on "*General Information*", then click on "*Voluntary Efficient Litigation Stipulations*".

3. The parties will prepare a joint report titled "Joint Status Report Pursuant to Initial Conference and Early Organizational Meeting Stipulation, and if desired, a proposed order summarizing results of their meet and confer and advising the Court of any way it may assist the parties' efficient conduct or resolution of the case. The parties shall attach the Joint Status Report to the Case Management Conference statement, and file the documents when the CMC statement is due.

4. References to "days" mean calendar days, unless otherwise noted. If the date for performing any act pursuant to this stipulation falls on a Saturday, Sunday or Court holiday, then the time for performing that act shall be extended to the next Court day

The following parties stipulate:

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR PLAINTIFF)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR _____)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR _____)

Date:

_____ (TYPE OR PRINT NAME) > _____ (ATTORNEY FOR _____)

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY.	STATE BAR NUMBER	Reserved for Clerk's File Stamp
TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES		
COURTHOUSE ADDRESS:		
PLAINTIFF:		
DEFENDANT:		
STIPULATION – DISCOVERY RESOLUTION		CASE NUMBER:

This stipulation is intended to provide a fast and informal resolution of discovery issues through limited paperwork and an informal conference with the Court to aid in the resolution of the issues.

The parties agree that:

1. Prior to the discovery cut-off in this action, no discovery motion shall be filed or heard unless the moving party first makes a written request for an Informal Discovery Conference pursuant to the terms of this stipulation.

2. At the Informal Discovery Conference the Court will consider the dispute presented by parties and determine whether it can be resolved informally. Nothing set forth herein will preclude a party from making a record at the conclusion of an Informal Discovery Conference, either orally or in writing.

3. Following a reasonable and good faith attempt at an informal resolution of each issue to be presented, a party may request an Informal Discovery Conference pursuant to the following procedures:

   a. The party requesting the Informal Discovery Conference will:

      i. File a Request for Informal Discovery Conference with the clerk's office on the approved form (copy attached) and deliver a courtesy, conformed copy to the assigned department;

      ii. Include a brief summary of the dispute and specify the relief requested; and

      iii. Serve the opposing party pursuant to any authorized or agreed method of service that ensures that the opposing party receives the Request for Informal Discovery Conference no later than the next court day following the filing.

   b. Any Answer to a Request for Informal Discovery Conference must:

      i. Also be filed on the approved form (copy attached);

      ii. Include a brief summary of why the requested relief should be denied;

SHORT TITLE:	CASE NUMBER:

iii. Be filed within two (2) court days of receipt of the Request; and

iv. Be served on the opposing party pursuant to any authorized or agreed upon method of service that ensures that the opposing party receives the Answer no later than the next court day following the filing.

c. No other pleadings, including but not limited to exhibits, declarations, or attachments, will be accepted.

d. If the Court has not granted or denied the Request for Informal Discovery Conference within ten (10) days following the filing of the Request, then it shall be deemed to have been denied. If the Court acts on the Request, the parties will be notified whether the Request for Informal Discovery Conference has been granted or denied and, if granted, the date and time of the Informal Discovery Conference, which must be within twenty (20) days of the filing of the Request for Informal Discovery Conference.

e. If the conference is not held within twenty (20) days of the filing of the Request for Informal Discovery Conference, unless extended by agreement of the parties and the Court, then the Request for the Informal Discovery Conference shall be deemed to have been denied at that time.

4. If (a) the Court has denied a conference or (b) one of the time deadlines above has expired without the Court having acted or (c) the Informal Discovery Conference is concluded without resolving the dispute, then a party may file a discovery motion to address unresolved issues.

5. The parties hereby further agree that the time for making a motion to compel or other discovery motion is tolled from the date of filing of the Request for Informal Discovery Conference until (a) the request is denied or deemed denied or (b) twenty (20) days after the filing of the Request for Informal Discovery Conference, whichever is earlier, unless extended by Order of the Court.

   It is the understanding and intent of the parties that this stipulation shall, for each discovery dispute to which it applies, constitute a writing memorializing a "specific later date to which the propounding [or demanding or requesting] party and the responding party have agreed in writing," within the meaning of Code Civil Procedure sections 2030.300(c), 2031.320(c), and 2033.290(c).

6. Nothing herein will preclude any party from applying *ex parte* for appropriate relief, including an order shortening time for a motion to be heard concerning discovery.

7. Any party may terminate this stipulation by giving twenty-one (21) days notice of intent to terminate the stipulation.

8. References to "days" mean calendar days, unless otherwise noted. If the date for performing any act pursuant to this stipulation falls on a Saturday, Sunday or Court holiday, then the time for performing that act shall be extended to the next Court day.

SHORT TITLE:	CASE NUMBER:

The following parties stipulate:

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR PLAINTIFF)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR DEFENDANT)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR DEFENDANT)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR DEFENDANT)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR _____)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR _____)

Date: _____
(TYPE OR PRINT NAME) _____
➢ _____
(ATTORNEY FOR _____)

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER	Reserved for Clerk's File Stamp
TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES		
COURTHOUSE ADDRESS:		
PLAINTIFF:		
DEFENDANT:		
INFORMAL DISCOVERY CONFERENCE (pursuant to the Discovery Resolution Stipulation of the parties)		CASE NUMBER:

1. This document relates to:
   - ☐ Request for Informal Discovery Conference
   - ☐ Answer to Request for Informal Discovery Conference
2. Deadline for Court to decide on Request: _____ (Insert date 10 calendar days following filing of the Request).
3. Deadline for Court to hold Informal Discovery Conference: _____ (Insert date 20 calendar days following filing of the Request).
4. **For a Request for Informal Discovery Conference, briefly describe the nature of the discovery dispute, including the facts and legal arguments at issue. For an Answer to Request for Informal Discovery Conference, briefly describe why the Court should deny the requested discovery, including the facts and legal arguments at issue.**

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY:	STATE BAR NUMBER	Reserved for Clerk's File Stamp
TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES		
COURTHOUSE ADDRESS:		
PLAINTIFF:		
DEFENDANT:		
STIPULATION AND ORDER – MOTIONS IN LIMINE		CASE NUMBER:

This stipulation is intended to provide fast and informal resolution of evidentiary issues through diligent efforts to define and discuss such issues and limit paperwork.

The parties agree that:

1. At least _____ days before the final status conference, each party will provide all other parties with a list containing a one paragraph explanation of each proposed motion in limine. Each one paragraph explanation must identify the substance of a single proposed motion in limine and the grounds for the proposed motion.

2. The parties thereafter will meet and confer, either in person or via teleconference or videoconference, concerning all proposed motions in limine. In that meet and confer, the parties will determine:

   a. Whether the parties can stipulate to any of the proposed motions. If the parties so stipulate, they may file a stipulation and proposed order with the Court.

   b. Whether any of the proposed motions can be briefed and submitted by means of a short joint statement of issues. For each motion which can be addressed by a short joint statement of issues, a short joint statement of issues must be filed with the Court 10 days prior to the final status conference. Each side's portion of the short joint statement of issues may not exceed three pages. The parties will meet and confer to agree on a date and manner for exchanging the parties' respective portions of the short joint statement of issues and the process for filing the short joint statement of issues.

3. All proposed motions in limine that are not either the subject of a stipulation or briefed via a short joint statement of issues will be briefed and filed in accordance with the California Rules of Court and the Los Angeles Superior Court Rules.

SHORT TITLE:	CASE NUMBER:

The following parties stipulate:

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR PLAINTIFF)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR DEFENDANT)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR _____)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR _____)

Date:

_____ (TYPE OR PRINT NAME)

> _____ (ATTORNEY FOR _____)

THE COURT SO ORDERS.

Date: _____

_____
JUDICIAL OFFICER

Superior Court of California
County of Los Angeles

ALTERNATIVE DISPUTE RESOLUTION (ADR)
INFORMATION PACKET

The person who files a civil lawsuit (plaintiff) must include the ADR information Packet with the complaint when serving the defendant. Cross-complainants must serve the ADR Information Packet on any new parties named to the action together with the cross-complaint.

There are a number of ways to resolve civil disputes without having to sue someone. These alternatives to a lawsuit are known as alternative dispute resolution (ADR).

In ADR, trained, impartial persons decide disputes or help parties decide disputes themselves. These persons are called neutrals. For example, in mediations, the neutral is the mediator. Neutrals normally are chosen by the disputing parties or by the court. Neutrals can help resolve disputes without having to go to court.

LAADR 005 (Rev. 03/17)
LASC Adopted 10-03
Cal. Rules of Court, rule 3.221

Advantages of ADR

- Often faster than going to trial
- Often less expensive, saving the litigants court costs, attorney's fees and expert fees.
- May permit more participation, allowing parties to have more control over the outcome.
- Allows for flexibility in choice of ADR processes and resolution of the dispute.
- Fosters cooperation by allowing parties to work together with the neutral to resolve the dispute and mutually agree to remedy.
- There are fewer, if any, court appearances. Because ADR can be faster and save money, it can reduce stress.

Disadvantages of ADR - ADR may not be suitable for every dispute.

- If ADR is binding, the parties normally give up most court protections, including a decision by a judge or jury under formal rules of evidence and procedure, and review for legal error by an appellate court.
- ADR may not be effective if it takes place before the parties have sufficient information to resolve the dispute.
- The neutral may charge a fee for his or her services.
- If the dispute is not resolved through ADR, the parties may then have to face the usual and traditional costs of trial, such as attorney's fees and expert fees.

The Most Common Types of ADR

- **Mediation**

  In mediation, a neutral (the mediator) assists the parties in reaching a mutually acceptable resolution of their dispute. Unlike lawsuits or some other types of ADR, the parties, rather than the mediator, decide how the dispute is to be resolved.

  - **Mediation is particularly effective** when the parties have a continuing relationship, like neighbors or business people. Mediation is also very effective where personal feelings are getting in the way of a resolution. This is because mediation normally gives the parties a chance to express their feelings and find out how the other sees things.

  - **Mediation may not be effective** when one party is unwilling to cooperate or compromise or when one of the parties has a significant advantage in power over the other. Therefore, it may not be a good choice if the parties have a history of abuse or victimization.

- **Arbitration**

  In arbitration, a neutral person called an "arbitrator" hears arguments and evidence from each side and then decides the outcome of the dispute. Arbitration is typically less formal than a trial, and the rules of evidence may be relaxed. Arbitration may be either "binding" or "non-binding." Binding arbitration means the parties waive their right to a trial and agree to accept the arbitrator's decision as final. Non-binding arbitration means that the parties are free to request a trial if they reject the arbitrator's decision.

  Arbitration is best for cases where the parties want another person to decide the outcome of their dispute for them but would like to avoid the formality, time, and expense of a trial. It may also be appropriate for complex matters where the parties want a decision-maker who has training or experience in the subject matter of the dispute.

- **Mandatory Settlement Conference (MSC)**

  Settlement Conferences are appropriate in any case where settlement is an option. Mandatory Settlement Conferences are ordered by the Court and are often held near the date a case is set for trial. The parties and their attorneys meet with a judge who devotes his or her time exclusively to preside over the MSC. The judge does not make a decision in the case but assists the parties in evaluating the strengths and weaknesses of the case and in negotiating a settlement.

  The Los Angeles Superior Court Mandatory Settlement Conference (MSC) program is free of charge and staffed by experienced sitting civil judges who devote their time exclusively to presiding over MSCs. The judges participating in the judicial MSC program and their locations are identified in the List of Settlement Officers found on the Los Angeles Superior Court website at http://www.lacourt.org/. This program is available in general jurisdiction cases with represented parties from Independent calendar (IC) and Central Civil West (CCW) courtrooms. In addition, on an ad hoc basis, personal injury cases may be referred to the program on the eve of trial by the personal injury master calendar courts in the Stanley Mosk Courthouse or the asbestos calendar court in CCW.

  In order to access the Los Angeles Superior Court MSC Program the judge in the IC courtroom, the CCW Courtroom or the personal injury master calendar courtroom must refer the parties to the program. Further, all parties must complete the information requested in the Settlement Conference Intake Form and email the completed form to mscdept18@lacourt.org.

Additional Information

To locate a dispute resolution program or neutral in your community:

- Contact the California Department of Consumer Affairs (www.dca.ca.gov) Consumer Information Center toll free at 800-952-5210, or;
- Contact the local bar association (http://www.lacba.org/) or;
- Look in a telephone directory or search online for "mediators; or "arbitrators."

There may be a charge for services provided by private arbitrators and mediators.

A list of approved State Bar Approved Mandatory Fee Arbitration programs is available at http://calbar.ca.gov/Attorneys/MemberServices/FeeArbitration/ApprovedPrograms.aspx#19

To request information about, or assistance with, dispute resolution, call the number listed below. Or you may call a Contract Provider agency directly. A list of current Contract Provider agencies in Los Angeles County is available at the link below.

http://css.lacounty.gov/programs/dispute-resolution-program-drp/

County of Los Angeles Dispute Resolution Program
3175 West 6th Street, Room 406
Los Angeles, CA 90020-1798
TEL: (213) 738-2621
FAX: (213) 386-3995

COPY

CALLAHAN & BLAINE, APLC
Daniel J. Callahan (Bar No. 91490)
Edward Susolik (Bar No. 151081)
Richard T. Collins (Bar No. 166577)
Damon D. Eisenbrey (Bar No. 215927)
3 Hutton Centre Drive, Ninth Floor
Santa Ana, California 92707
Telephone: (714) 241-4444
Facsimile: (714) 241-4445

Attorneys for Plaintiff Ohad Barkan,
individually and on behalf of all others similarly situated

CONFORMED COPY
ORIGINAL FILED
Superior Court of California
County of Los Angeles

JUN 29 2018

Sherri R. Carter, Executive Officer/Clerk
By: Bailey Smith, Deputy
Bailey Smith

SUPERIOR COURT OF CALIFORNIA

COUNTY OF LOS ANGELES

OHAD BARKAN, individually and on behalf of all others similarly situated,

Plaintiff,

v.

HEALTH NET OF CALIFORNIA, INC., a California corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation; MANAGED HEALTH NETWORK, INC., a Delaware corporation; HEALTH NET, INC., a Delaware corporation; CENTENE CORPORATION, a Delaware corporation; and DOES 1 through 100, inclusive,

Defendants.

CASE NO. BC 711987

COMPLAINT

Complaint Filed:
Trial Date:

BY FAX

CALLAHAN & BLAINE
A PROFESSIONAL LAW CORPORATION
3 HUTTON CENTRE DRIVE, NINTH FLOOR
SANTA ANA, CALIFORNIA 92707
TELEPHONE: (714) 241-4444
WWW.CALLAHAN-LAW.COM

Plaintiff Ohad Barkan, also known as Ady Barkan, brings this action for himself individually and on behalf of all others similarly situated ("Class Members"), against defendants Health Net of California, Inc., a California corporation, Health Net Life Insurance Company, a California corporation, Managed Health Network, Inc., a Delaware corporation, Health Net, Inc., a Delaware corporation, Centene Corporation, a Delaware corporation (collectively "Health Net"), and Does 1 through 100, inclusive, and alleges on information and belief, except as to those allegations pertaining to Mr. Barkan that are alleged on personal knowledge, as follows:

THE PARTIES

1. Mr. Barkan is a citizen of the State of California and resides in Santa Barbara County.

2. Defendant Health Net of California, Inc. ("HNCI") is, and was at all times relevant to this action, a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in Woodland Hills, California. HNCI is authorized to conduct business as a health care service plan and health care insurer, and transacts, and is transacting, the business of providing health plans to consumers throughout California.

3. Defendant Health Net Life Insurance Company ("HNLIC") is, and was at all times relevant to this action, a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in Woodland Hills, California. HNLIC is authorized to conduct business as a health care service plan and health care insurer, and transacts, and is transacting, the business of providing health plans to consumers throughout California.

4. Defendant Managed Health Network, Inc. ("MHNI") is, and was at all times relevant to this action, a corporation duly organized and existing under the laws of the State of Delaware, with its principal place of business located in Woodland Hills, California. MHNI is authorized to conduct business as a health care service plan and health care insurer, and transacts, and is transacting, the business of providing health plans to consumers throughout California.

5. Defendant Health Net, Inc. ("HNI") is, and was at all times relevant to this action, a corporation duly organized and existing under the laws of the State of Delaware, with its principal place of business located in Woodland Hills, California. HNI is authorized to conduct business as

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a health care service plan and health care insurer, and transacts, and is transacting, the business of providing health plans to consumers throughout California.

6. Defendant Centene Corporation ("Centene") is, and was at all times relevant to this action, a corporation duly organized and existing under the laws of the State of Delaware, with its principal place of business located in St. Louis, Missouri. Centene is authorized to conduct business as a health care service plan and health care insurer, and transacts, and is transacting, the business of providing health plans to consumers throughout California.

7. Centene acquired HNI, HNCI, HNLIC, and MHNI through merger in 2015, which was approved by the California Department of Managed Health Care ("DMHC") and the California Department of Insurance ("CDI") in 2016, and is now the parent company or successor in interest of, and thereby liable for the acts and omissions of HNI, HNCI, HNLIC, and MHNI.

8. Mr. Barkan does not know the true names and capacities of defendants sued as Does 1 through 100, inclusive, and therefore sues such defendants with such fictitious names. Mr. Barkan will amend this complaint, if necessary, to allege their true names and capacities when they have been ascertained. Mr. Barkan is informed and believes that each of the named and fictitiously named defendants are in some way involved in and responsible for the events, transactions, or occurrences alleged in the complaint, as well as the damages caused to Mr. Barkan. Does 1 through 100 are included in the references throughout this complaint to HNI, HNCI, HNLIC, MHNI, and Centene, as appropriate.

9. Each of the defendants is, and was at all times relevant to this action, the agent, servant, representative, or alter ego of each of the other defendants, and in doing the things hereinafter alleged, each of the defendants was acting in the scope of its authority as such agent, servant, representative, or alter ego, and with the permission and consent of each of the other defendants.

10. Each of the defendants formed and operated a conspiracy with each of the other defendants to perform the acts alleged herein, in furtherance of a common design and with knowledge that the conduct alleged herein of each of the defendants constituted breaches of duty and provided substantial assistance or encouragement to each other to so act.

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3 HUTTON CENTRE DRIVE, NINTH FLOOR
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TELEPHONE: (714) 241-4444
WWW.CALLAHAN-LAW.COM

11. Defendants HNI, HNCI, HNLIC, MHNI, Centene and Does 1 through 100, inclusive, and each of them, are collectively referred to herein as "Health Net," unless referred to in their individual capacities.

NATURE OF THE ACTION

12. In California, regulation and oversight of consumer health care is split between two public agencies – the CDI with regulatory oversight of health insurance companies, and the DMHC with regulatory oversight of health care service plans, such as health maintenance organizations ("HMOs"). Whereas health insurance policies generally embody a *promise to pay* for health care, health care service plans embody a *promise to deliver* health care. In either event, insurance companies have been entrusted with ensuring consumers have access to medically necessary health care in a timely manner.

13. Mr. Barkan brings this action as a result of Health Net's breach of its promise to deliver covered, medically necessary health care, and to challenge Health Net's bad faith, deceptive and unfair administration of the Health Net Blue & Gold HMO pursuant to the Evidence of Coverage (EOC), including Health Net's prior authorization and utilization review process for plan members seeking covered services, and Health Net's adjudication and administration of claims for covered services made under such plans, which skews the determination of coverage for medically necessary services toward denial.

14. Mr. Barkan seeks damages and equitable injunctive and declaratory relief for contract and tort claims arising out of Health Net's denial of prior authorization and refusal to provide coverage for medically necessary durable medical equipment – Trilogy 100 non-invasive ventilation machine – and for medically necessary prescription medication – Edaravone (Radicava).

15. Mr. Barkan and the Class Members seek to enjoin Health Net's continued statutory violations, bad faith, deceptive and unfair claims practices and administration of health care service plans, including:

a. The prior authorization and utilization review process for plan members seeking covered services and the adjudication and administration of claims for covered services

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made under such plans, which skews the determination of coverage for services, supplies, equipment and prescription medication toward denial, including upon the basis that such medically necessary services, supplies, equipment or prescription medication is "Experimental or Investigational," or not "Medically Necessary;"

b. The draconian procedures for grievances, appeals, independent medical reviews and, ultimately mandatory binding arbitration, for those plan members who can survive long enough, pursuant to an unconscionable and unenforceable arbitration provision in the 90-plus page EOC; and

c. The coordination of benefits process that interferes with and delays the delivery of plan members' pre-authorized, medically necessary health care while Health Net seeks to shift financial responsibility for the member's care to another health care service plan or health insurer.

16. Mr. Barkan and the Class Members seek restitution of all monies paid for Health Net health care service plans and health insurance policies in an amount reflecting the difference in the value of the health plans with the broader coverages and benefits as misrepresented in Health Net's EOC issued at any time on or after October 1, 2013, and the value of the health plans with the actual, limited coverages and benefits as the terms of the EOC are interpreted and applied by Health Net in the administration and adjudication of claims, and other remedies as set forth herein.

17. Mr. Barkan and the Class Members seek declaratory relief as to the respective rights and obligations of the parties to the EOC, with specific findings that:

a. The exclusion in the EOC for "Experimental or Investigational Services" is ambiguous and unenforceable;

b. The mandatory binding arbitration provision in the EOC does not comply with the Knox-Keene Act and is unenforceable; and

c. The mandatory binding arbitration provision in the EOC is unconscionable and unenforceable.

18. Mr. Barkan was covered under Health Net's Blue & Gold HMO as a covered

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family member under the plan provided by the University of California, his wife Rachel King's employer. A true and correct copy of Mr. Barkan's EOC is attached as Exhibit A and incorporated by reference as though set forth in full in this complaint.

19. The Class Members were covered under Health Net's Blue & Gold HMO, or Health Net's private individual and family HMO health care service plans and PPO insurance policies, compliant with the mandates of the Patient Protection and Affordable Care Act ("ACA"), sold through the Covered California exchange, beginning with the 2014 Open Enrollment Period, October 1, 2013 through March 31, 2014, and thereafter through the present.

DMHC Regulation of Health Care Service Plans

20. Health Net's Blue & Gold HMO and those HMO plans sold through Covered California are subject to the requirements of California Health and Safety Code sections 1340 through 1399.99 (the "Knox-Keene Act").

21. In adopting the Knox-Keene Act, it was the "intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California" by:

a. "Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace." Health & Saf. Code § 1342(b).

b. "Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public." Id. at subd. (c).

c. "Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers." Id. at subd. (d).

22. Health and Safety Code section 1367, subdivision (h)(1), provides that "contracts with subscribers and enrollees … shall be fair, reasonable, and consistent with the objectives of [the Knox-Keene Act]."

23. To further the goals of ensuring that consumers are educated and informed about

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the coverage and benefits and enabling consumer choice in the market place, the Knox-Keene Act bars health care service plans from using "any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive." Health & Saf. Code § 1360(a). Under this statute, no health care service plan "shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact." Id. at subd. (b). For the purposes of this statute:

a. "A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee or subscriber, or potential enrollee or subscriber in a plan." Id. at subd. (a)(1).

b. "A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or potential enrollee or subscriber, in a plan, and such is not the case." Id. at subd. (a)(2).

24. Additionally, the Knox-Keene Act requires regulators to "develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner." Health & Saf. Code § 1367.03(a). Under these regulations (Title 28 of the California Code of Regulations ["28 CCR"] § 1300.67.2, et seq.):

a. "Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." 28 CCR § 1300.67.2.2(c)(10).

b. "Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies,

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procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard." 28 CCR § 1300.67.2.2(c)(1).

c. "[E]ach plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet [certain] timeframes[.]" 28 CCR § 1300.67.2.2(c)(5).

CDI Regulation of Health Insurance Companies

25. Health Net's PPO health insurance policies sold through Covered California are subject to the requirements of the California Insurance Code.

26. To further the goals of ensuring that consumers are educated and informed about the coverage and benefits and enabling consumer choice in the market place, regulations promulgated pursuant to the Insurance Code require that advertisements for health plans "shall be truthful and not misleading in fact or in implication." Cal: Code Regs. Title lo ["10 CCR"] § 2536.1(b).

27. Insurance Code sections 10603 and 10604 require health insurers to "provide [information], in easily understood language and in a uniform, clearly organized manner," including the "principal benefits and coverage of the [health] insurance policy" and the "exceptions, reductions, and limitations that apply to such policy."

28. Insurance Code section 10133.5 provides "that insureds have opportunity to access needed health care services in a timely manner ... to assure accessibility of provider services in a timely manner to individuals ... pursuant to benefits covered under the policy or contract." Id. at subds. (a) and (b). The purpose of the statute is to ensure, among other things, that:

a. "The policy or contract is not inconsistent with standards of good health care and clinically appropriate care." Ins. Code § 10133.5(b)(3).

b. "All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable." Ins. Code § 10133.5(b)(4).

29. To ensure that enrollees have access to needed health care services in a timely manner, regulations promulgated pursuant to Insurance Code section 10133.5 provide that "insurers shall ensure that ... [n]etwork providers are duly licensed or accredited and that they are

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sufficient, in number or size, to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services." 10 CCR § 2240.1(b)(1).

JURISDICTION AND VENUE

30. This Court has jurisdiction over this action under Article VI, section 10 of the California Constitution and section 410.10 of the Code of Civil Procedure. Jurisdiction is also proper under Business and Professions Code section 17200, et seq. and Civil Code section 1750, et seq.

31. This Court has jurisdiction over Health Net, a resident of the State of California.

32. Jurisdiction over Health Net is also proper because Health Net has purposely availed itself of the privilege of conducting business activities in California and because Health Net currently maintains systematic and continuous business contacts with this State, and has many thousands of enrollees who are residents of this State and who do business with Health Net.

33. Venue is proper in this Court because Health Net's principle place of business is in the County of Los Angeles; because Health Net engages and performs business activities in the County of Los Angeles; and because Health Net has also received substantial profits from consumers who reside in the County of Los Angeles.

FACTUAL ALLEGATIONS

34. Mr. Barkan is a 34-year old male who lives in Santa Barbara with his wife Rachel King and their son Carl. Mr. Barkan graduated from Columbia University and Yale Law School, was admitted to the New York Bar in 2011, clerked for the Hon. Shira A. Scheindlin in the Southern District of New York, and currently works for The Center for Popular Democracy. Ms. King also graduated from Columbia University, obtained her Ph.D. in English and American Literature at New York University, and is an English Literature professor at the University of California, Santa Barbara.

35. Mr. Barkan and Ms. King began dating during their senior year of college. In the

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fall of 2015, they celebrated 10 years together by getting married, and in May 2016, Carl was born. Life was perfect.

36. Then, in October 2016, Mr. Barkan was diagnosed with amyotrophic lateral sclerosis ("ALS"), also known as Lou Gehrig's disease, a group of rare neurological diseases that mainly involve the nerve cells (neurons) responsible for controlling voluntary muscle movement. Voluntary muscles produce movements like chewing, walking, and talking. The disease is progressive, meaning the symptoms get worse over time. Currently, there is no cure for ALS and no effective treatment to halt, or reverse, the progression of the disease.

37. Early symptoms of ALS usually include muscle weakness or stiffness. Gradually all muscles under voluntary control are affected, and individuals lose their strength and the ability to speak, eat, move, and even breathe. Most people with ALS die from respiratory failure, usually within three to five years from when the symptoms first appear.

38. Mr. Barkan walks with a cane and needs a ventilator to breathe. He has been told that he has three to four years to live. Death is something that sits very close and omnipresent for Mr. Barkan and those who suffer with a life-threatening or seriously debilitating health condition, as they survive on a day-to-day basis with the fate of their medically necessary health care in the hands of insurance companies like Health Net.

39. Mr. Barkan had been receiving his health care coverage through an employer-provided plan with Cigna, and had been treating with Karen DaSilva, M.D., a neurologist in Santa Barbara, a provider within Cigna's network. Mr. Barkan discontinued his Cigna plan January 1, 2018, and enrolled in the Health Net Blue & Gold HMO with his wife and son. Dr. DaSilva also is a provider within Health Net's network, which should have precluded any interference with Mr. Barkan's continuity of care.

40. When Dr. DaSilva determined it was medically necessary for Mr. Barkan to use a ventilator and take the prescription medication, Edaravone (Radicava), Health Net's prior authorization was required for the durable medical equipment and prescription medication to be covered.

41. Dr. DaSilva's office requested Health Net's authorization to proceed with the

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prescribed plan of treatment on or about January 10, 2018, to include Radicava injectable 30 mg/100 ml, and a Trilogy 100 non-invasive ventilation machine.

42. Health Net denied authorization for the Radicava by letter, dated January 18, 2018, signed by Jamie K., Pharm.D., Clinical Pharmacist for HNCI, on the grounds that it was not medically necessary as determined by the Health Net's clinical policy.

43. The provisions of the EOC bearing on medical necessity provide as follows:

> You are entitled to receive Medically Necessary services and supplies … when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

44. The EOC defines "Medically Necessary" in pertinent part as follows:

> Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
>
> > 1. In accordance with generally accepted standards of medical practice;
> >
> > 2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
> >
> > 3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. …

45. Health Net also denied authorization for the ventilator on the grounds that it was experimental or investigational as determined by the Health Net's clinical policy, though Health Net never expressed this basis for denial in writing.

46. The EOC contains the following exclusion:

> **Experimental or Investigational Services**
>
> Experimental or Investigational drugs, devices, procedures or other therapies are **only covered except when**:

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- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of "General Provisions," Section 7 for more information; or

- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Clinical Trials" provision in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5. ...

47. To challenge Health Net's denial, Mr. Barkan was required to first file a grievance or appeal with Health Net, or request an independent medical review with the DMHC. If dissatisfied with the grievance or appeal process, Health Net contends the terms of the EOC mandate that binding arbitration is the sole and final process for resolution of disputes Mr. Barkan may have with Health Net. However, the mandatory binding arbitration provision is not properly disclosed on Health Net's enrollment form, in violation of the Knox-Keene Act, and the disclosure conflicts with the arbitration provision in the EOC.

48. The Knox-Keene Act has certain requirements re binding arbitration agreements in a health care service plan like an HMO.

> Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:
>
> (a) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.
>
> (b) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.
>
> (c) The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.
>
> (d) In any contract or enrollment agreement for a health care service plan, the disclosure required by this section **shall be displayed ... immediately before the signature line provided for the individual enrolling in the health care service plan.**

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Health & Saf. Code, 1363.1, emphasis added.

49. There is no disclosure of mandatory binding arbitration immediately before signature line on the enrollment form:

50. The enrollment form does contain a disclosure of mandatory binding arbitration (on a page **after** the enrollee's signature line), but the disclosure only states that medical malpractice claims will be resolved by binding arbitration:

> UC-sponsored medical plans require resolution of disputes through arbitration. With regard to each plan, by your written or electronic signature, IT IS UNDERSTOOD AND YOU AGREE THAT **ANY DISPUTE AS TO MEDICAL MALPRACTICE** ... WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THE CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION. For more information about each plan's arbitration provision please see the appropriate plan booklet or call the plan.

51. In the EOC, the arbitration provision reads as follows:

> **Binding Arbitration**
>
> Sometimes disputes or disagreements may arise between you (including your enrolled Family Members ...) and Health Net **regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership.** ... Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise and whether or not other parties such as employer groups, health care providers or their agents or employees, are also involved. **In addition, disputes with Health Net involving alleged professional liability or medical malpractice** ... also must be submitted to binding arbitration.
>
> As a condition to becoming a Health Net Member, you agree to submit **all disputes** you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. ...

52. The mandatory binding arbitration provision further provides the following

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unconscionable provisions:

> ... The arbitrator may interpret this Evidence of Coverage, **but will not have any power to change, modify or refuse to enforce any of its terms**, nor will the arbitrator have the authority to make any award that would not be available in a court of law. ...

53. In essence, Health Net seeks without disclosure not only to preclude the insured member's right to a jury trial, but to also preclude the insured member from seeking equitable relief, reformation, declaratory relief and injunctive relief, by stripping the arbitrator of "any power to change, modify or refuse to enforce any of [the EOC's] terms."

54. The mandatory binding arbitration provision also imposes an unconscionable financial burden on insured members: "The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration." This financial burden is intended to and does discourage insured members from vindicating their rights.

55. Mr. Barkan appealed the denials. In a letter, dated January 27, 2018, signed by Jasmit B., Appeals and Grievances Case Coordinator for HNCI, Health Net approved authorization for six months of the Radicava, overturning its denial after a review of Mr. Barkan's medical records by Health Net Medical Director Jacqueline Do, M.D.

56. Health Net also overturned its denial and authorized the ventilator, though again Health Net did not express in writing its position on the ventilator.

57. Health Net's Senior Director of Appeals and Grievances, Danielle Henderson, sent a letter to Mr. Barkan, dated February 8, 2018, to express Health Net's position on coverage for the Rubicava and ventilator. In the letter, Ms. Henderson acknowledged that the initial information Health Net provided to Mr. Barkan and Dr. DaSilva – that coverage for the ventilator was being denied pursuant to the "Experimental or Investigational" exclusion – was "not accurate." In fact, Ms. Henderson admitted that, "Health Net does not consider this medical equipment experimental in your situation."

58. Ms. Henderson raised a new argument in her February 8, 2018, letter to justify Health Net's bad faith denial of coverage: "At that time [when the request for authorization was received], Health Net was not your primary insurer, and the request should have been directed to

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your primary insurer, Cigna." Not only is this excuse factually inaccurate, but interfering with Mr. Barkan's access to health care because of coordination of benefits activities is contrary to the law and the express terms of the EOC.

59. Mr. Barkan acknowledges that Health Net has overturned its denial of coverage for both the ventilator and Rubicava medication. However, that does not erase the significant emotional distress Mr. Barkan endured as he wondered how he was to live without the medically necessary ventilator and medication prescribed by Dr. DaSilva. Furthermore, Health Net has not authorized the ventilator indefinitely, and the Rubicava was only authorized for six months (through June 30, 2018). Mr. Barkan not only seeks damages but a declaration of rights under the EOC to prevent further denials, delays and interference with his medically necessary health care.

60. Moreover, Mr. Barkan is not alone. The Class Members have also suffered, and in the future will suffer, wrongful denials of claims because of Health Net's ambiguous "Experimental or Investigational" and "Medically Necessary" exclusions; delays and interference with access to medically necessary health care because of Health Net's draconian procedures for grievances, appeals, independent medical reviews and mandatory binding arbitration pursuant to an unconscionable and unenforceable arbitration provision; and further delays and interference with access to medically necessary health care because of Health Net's coordination of benefits process that focuses on shifting financial responsibility for the member's care as opposed to ensuring continuity of care.

CLASS ALLEGATIONS

61. Mr. Barkan brings this action for himself individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382 and Civil Code section 1781. Mr. Barkan seeks to represent the following class:

> All California residents enrolled in Health Net's Blue & Gold HMO, or Health Net's private individual and family HMO health care service plans and PPO insurance policies sold through the Covered California exchange on or after October 1, 2013.

62. Mr. Barkan reserves the right under Rule 3.765(b) of the California Rules of Court to amend or modify the class description with greater specificity, by further division into

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subclasses or by limitation to particular issues.

63. The proposed Class is composed of thousands of persons dispersed throughout the State of California and joinder is impractical. The precise number and identity of Class Members are unknown to Mr. Barkan but can be obtained from Health Net's records.

64. There are questions of law and fact common to the Class Members that predominate over questions affecting only individual Class Members.

65. Mr. Barkan is a Class Member and his claims are typical of the other Class Members' claims.

66. Mr. Barkan is willing and prepared to serve the Court and the proposed Class in a representative capacity. Mr. Barkan will fairly and adequately protect the interests of the Class and have no interests adverse to or which conflict with the interests of the other Class Members.

67. Mr. Barkan's self-interest is co-extensive with and not antagonistic to those of absent Class Members. Mr. Barkan will undertake to represent and protect the interests of absent Class Members.

68. Mr. Barkan has engaged the services of counsel indicated below who are experienced in complex class litigation, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent Mr. Barkan and absent Class Members.

69. The prosecution of separate actions by individual Class Members would create a risk of inconsistency and varying adjudications, establishing incompatible standards of conduct for Health Net.

70. Health Net has acted on grounds generally applicable to the Class, thereby making relief with respect to the Class Members as a whole appropriate.

71. A class action is superior to other available means for the fair and efficient adjudication of this controversy. Prosecution of the complaint as a class action will provide redress for individual claims too small to support the expense of complex litigation and reduce the possibility of repetitious litigation.

72. Mr. Barkan does not anticipate any unusual or difficult management problems with the pursuit of this Complaint as a class action.

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FIRST CAUSE OF ACTION

Breach of Written Contract

Against All Defendants

73. Mr. Barkan incorporates by reference each of the preceding paragraphs as though fully set forth herein.

74. Pursuant to the terms and conditions of Mr. Barkan's Blue & Gold HMO EOC, attached as Exhibit A, defendants and each of them had a duty to promptly provide access to medically necessary health care services, supplies and medication.

75. Defendants and each of them further had a duty to thoroughly investigate requests for care and fully inquire into all possible bases that might support the request for care (see Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d 809, 819), and to evaluate a request for authorization with a utilization review process conducted by a clinical professional only after all of the insured member's health records have been obtained and reviewed, and, if still necessary, after speaking with the insured member or the member's treating physicians.

76. The duty of defendants and each of them included compliance with the National Committee for Quality Assurance ("NCQA") industry standards for HMOs titled, "Standards for the Accreditation of Managed Care Organizations" ("NCQA standards"), Standard UM 3, requiring that "qualified health professionals assess the clinical information used to support [utilization review] decisions." Additionally, an HMO must have procedures for "using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity." Health & Safety Code § 1367.01(e) provides that only a licensed physician or health care provider "who is competent to evaluate the specific clinical issues involved in the health care services requested" may deny a request for care based on medical necessity. HMOs must communicate decisions to delay, deny or modify requests for care in writing and provide a clear and concise explanation of the reasons for the HMO's decision, a description of the criteria or guidelines used, and clinical reasons for decisions regarding medical necessity. Health & Safety Code § 1367.01(h)(4).

77. Defendants and each of them further had a duty to not allow their coordination of

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benefits activities to interfere with Mr. Barkan's access to medically necessary health care services, supplies and medication.

78. Defendants and each of them breached these contractual duties by the conduct alleged herein, including without limitation, by not engaging in a prompt, full and complete investigation of Mr. Barkan's claims; by denying coverage and refusing authorization for the medically necessary durable equipment and medication prescribed by Mr. Barkan's health care professional, based upon ambiguous and inapplicable exclusions interpreted by Health Net in an unduly restrictive manner so as to deny coverage and benefits when, in fact, coverage exists and benefits are owed; by denying coverage without a utilization review process conducted by a clinical professional that had reviewed all of Mr. Barkan's health records have and, if still necessary, after speaking with Mr. Barkan or his treating physicians; and by imposing draconian procedures for grievances, appeals, independent medical reviews and, ultimately, for those plan members who can survive long enough to seek enforcement of their rights, mandatory binding arbitration pursuant to an unconscionable and unenforceable arbitration provision in the 90-plus page EOC.

79. There is no legally operative term in the EOC that would justify defendants' denial of coverage for the medically necessary durable equipment and medication prescribed by Mr. Barkan's health care professional.

80. Mr. Barkan has performed all duties required of him under the EOC, except as excused by defendants' material breaches.

81. As a direct and proximate result of defendants' breach, Mr. Barkan has suffered general and incidental damages according to proof, and is entitled to pre-judgment interest.

82. As a direct and proximate result of defendants' breach, Mr. Barkan has incurred and continues to incur economic loss, including the out of pocket expenses relating to defendants' denial of coverage and Mr. Barkan's efforts to appeal that coverage determination, and other consequences, all according to proof.

83. As a direct and proximate result of defendants' breach, Mr. Barkan has sustained damages, and pre-judgment interest, in excess of the jurisdictional minimum of this court in an

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amount to be determined at trial.

SECOND CAUSE OF ACTION

Breach of Implied Covenant of Good Faith and Fair Dealing

Against All Defendants

84. Mr. Barkan incorporates by reference each of the preceding paragraphs as though fully set forth herein.

85. Mr. Barkan's EOC contains an implied covenant of good faith and fair dealing that obligates each party to do nothing to injure the right of the other party to receive the benefits of the agreement.

86. Mr. Barkan has performed all duties required of him under the EOC, except as excused by defendants' material breaches.

87. Defendants and each of them, on the other hand, tortiously breached the EOC and the implied covenant of good faith and fair dealing by the conduct alleged herein, for which they had no reasonable or good faith basis.

88. The conduct of defendants and each of them as alleged herein constitutes part of an institutional illegal pattern and practice of bad faith and unlawful insurance practices, and constitutes a continuing tort that is causing Mr. Barkan continued damages.

89. As a direct and proximate result of defendants' breach, Mr. Barkan has suffered general and incidental damages according to proof, and is entitled to pre-judgment interest.

90. As a direct and proximate result of defendants' breach, Mr. Barkan has incurred and continues to incur economic loss, including the out of pocket expenses relating to defendants' denial of coverage and Mr. Barkan's efforts to appeal that coverage determination, including attorney fees and costs in pursuing this action, and other consequences, all according to proof.

91. As a direct and proximate result of defendants' breach, Mr. Barkan has incurred attorney fees and costs as a result of efforts to secure the insurance benefits owed, in an amount according to proof.

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92. As a direct and proximate result of defendants' breach, Mr. Barkan has sustained damages, and pre-judgment interest, in excess of the jurisdictional minimum of this court in an amount to be determined at trial.

93. The conduct of defendants and each of them as alleged herein was fraudulent, oppressive and malicious, was carried out with a conscious disregard of Mr. Barkan's rights, and constitutes despicable conduct intended to vex, injure and annoy Mr. Barkan. Defendants and each of them are guilty of oppression, fraud and malice under Civil Code section 3294, entitling Mr. Barkan to punitive damages in an amount appropriate to punish defendants and deter others from engaging in similar wrongful conduct.

94. The conduct of defendants and each of them as alleged herein was undertaken by defendants' officers, directors or managing agents, identified herein as Does 1 through 100, who were responsible for supervision, operation, reports, communication and decisions. The conduct of said officers, directors and managing agents, and of other employees, representatives and agents, was undertaken on behalf of defendants, which had advance knowledge of the action and conduct of said individuals whose conduct and actions were authorized, ratified and approved by officers, directors or managing agents of defendants, whose precise identities are unknown to Mr. Barkan at this time and are therefore identified and designated herein as Does 1 through 100.

THIRD CAUSE OF ACTION

Unfair Competition Law Violations (Bus. & Prof. Code § 17200, et seq.)

Against All Defendants

95. Mr. Barkan incorporates by reference each of the preceding paragraphs as though fully set forth herein.

96. The conduct of defendants and each of them as alleged herein not only constitutes common law bad faith, but also violates state and federal law, regulations and policies, and thus constitutes unlawful, unfair, and fraudulent business practices in violation of Business & Professions Code Section 17200, et seq. (the "UCL").

97. The conduct of defendants and each of them does not benefit consumers or competition. Indeed the injury to consumers and competition is substantial.

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98. Mr. Barkan and the Class Members could not have reasonably avoided the injury each of them suffered.

99. The gravity of the consequences of defendants' conduct as described above outweighs any justification, motive or reason, and is immoral, unethical, oppressive, unscrupulous and offends established public policy delineated in California law, the Knox Keene Act, the Insurance Code, and regulatory provisions as well as their underlying purposes.

100. Mr. Barkan and the Class Members have suffered injury in fact and have lost money or property as a result of acts of unfair competition by defendants and each of them as alleged herein.

101. Defendants and each of them, directly or indirectly, have engaged in substantially similar conduct toward Mr. Barkan and each Class Member.

102. Such wrongful actions and conduct are ongoing and continuing. Unless Defendants and each of them are enjoined from continuing to engage in such wrongful actions and conduct, the public will continue to be harmed by their conduct.

103. Mr. Barkan and the Class Members are entitled to injunctive relief under the UCL and, as such, Mr. Barkan and Class Members seek a temporary restraining order, a preliminary injunction, and a permanent injunction, all enjoining defendants and each of them from their continued statutory violations, bad faith, deceptive and unfair claims practices and administration of health care service plans, including:

a. The prior authorization and utilization review process for plan members seeking covered services and the adjudication and administration of claims for covered services made under such plans, which skews the determination of coverage for services, supplies, equipment and prescription medication toward denial, including upon the basis that such medically necessary services, supplies, equipment or prescription medication is "Experimental or Investigational," or not "Medically Necessary;"

b. The draconian procedures for grievances, appeals, independent medical reviews and, ultimately, for those plan members who can survive long enough to seek enforcement of their rights, mandatory binding arbitration pursuant to an unconscionable and unenforceable

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arbitration provision in the 90-plus page EOC; and

c. The coordination of benefits process that interferes with and delays the delivery of plan members' pre-authorized, medically necessary health care while Health Net seeks to shift financial responsibility for the member's care to another health care service plan or health insurer.

104. Mr. Barkan and the Class Members are further entitled to restitution of all monies paid for Health Net health care service plans and health insurance policies in an amount reflecting the difference in the value of the health plans with the broader coverages and benefits as misrepresented in Health Net's EOC issued at any time on or after October 1, 2013, and the value of the health plans with the actual coverages and benefits as the terms of the EOC are interpreted and applied by Health Net in the administration and adjudication of claims, and other remedies as set forth herein.

105. Mr. Barkan and the Class Members are further entitled to an order appointing a receiver over defendants and each of them, and restoring to Mr. Barkan any money or property that was acquired through the foregoing acts of unfair competition (Bus. & Prof. Code § 17203).

106. The conduct of defendants and each of them as alleged herein was fraudulent, oppressive and malicious, was carried out with a conscious disregard of Mr. Barkan and the Class Members' rights, and constitutes despicable conduct intended to vex, injure and annoy Mr. Barkan and the Class Members. Defendants and each of them are guilty of oppression, fraud and malice under Civil Code section 3294, entitling Mr. Barkan and the Class Members to punitive damages in an amount appropriate to punish defendants and deter others from engaging in similar wrongful conduct.

107. The conduct of defendants and each of them as alleged herein was undertaken by defendants' officers, directors or managing agents, identified herein as Does 1 through 100, who were responsible for supervision, operation, reports, communication and decisions. The conduct of said officers, directors and managing agents, and of other employees, representatives and agents, was undertaken on behalf of defendants, which had advance knowledge of the action and conduct of said individuals whose conduct and actions were authorized, ratified and approved by

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officers, directors or managing agents of defendants, whose precise identities are unknown to Mr. Barkan and the Class Members at this time and are therefore identified and designated herein as Does 1 through 100.

108. Mr. Barkan and the Class Members are also entitled to recover attorney fees pursuant to Code of Civil Procedure section 1021.5, as they are the catalyst for enforcement of important rights affecting the public interest that confer a significant benefit on the general public.

FOURTH CAUSE OF ACTION

Consumers Legal Remedies Act Violations (Civ. Code § 1750, et seq.)

Against All Defendants

109. Mr. Barkan incorporates by reference each of the preceding paragraphs as though fully set forth herein.

110. Under the Consumers Legal Remedies Act ("CLRA;" Civ. Code § 1750, et seq.), the following "unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or which results in the sale or lease of goods or services to any consumer are unlawful":

- "Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have." Civ. Code § 1770(a)(5).
- "Advertising goods or services with intent not to sell them as advertised." Civ. Code § 1770(a)(9).
- "Representing that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law." Civ. Code § 1770(a)(14).
- "Inserting an unconscionable provision in the contract." Civ. Code § 1770(a)(19).

111. Defendants and each of them have violated the CLRA, including but not limited to, Civil Code section 1770(a) subparagraphs (5), (9), (14), and (19) when they:

a. Advertised that their health plans would cover medically necessary services, supplies and medication, when in fact, the health plans as interpreted and applied by defendants

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excludes coverage for such health care based upon ambiguous and inapplicable exclusions interpreted by Health Net in an unduly restrictive manner, and based upon a utilization review process that is not conducted by a clinical professional who has reviewed all of the insured member's health records and, if still necessary, after speaking with the insured member or his treating physicians, so as to deny coverage and benefits when, in fact, coverage exists and benefits are owed;

b. Advertised that their coordination of benefits activities "will not interfere with your medical care," when in fact defendants and each of them deny coverage for medically necessary services, supplies and medication if the insured member has other insurance, and they pursue efforts to transfer their liability to another insurer while depriving their insured member of the health care they need and deserve; and

c. Advertised at the time of enrollment that their health plans include a mandatory binding arbitration provision that applies only to medical malpractice claims, when in fact defendants and each of them include a mandatory binding arbitration provision that purports to apply to "all disputes" an insured member may have with Health Net, and purports to mandate that the insured member waive his right to seek equitable relief and his right to a jury trial.

112. Defendants and each of them violated the CLRA by committing unfair and deceptive acts that directly undermined Mr. Barkan and the Class Members' ability to access medically necessary health care services, supplies and medication.

113. Mr. Barkan and the Class Members have suffered harm as a result of these violations. Mr. Barkan and the Class Members purchased health plan contracts, and renewed health plan contracts, reasonably relying on Health Net's material misrepresentations as alleged herein. Mr. Barkan and the Class Members have also suffered transactional costs by expending time and resources in an attempt to avoid the consequences of Health Net's unfair methods of competition and unfair or deceptive acts. Mr. Barkan and the Class Members have also suffered opportunity costs by foregoing the opportunity to switch to other coverage offered by other companies during the open enrollment periods.

114. The misrepresentations and omissions by defendants and each of them as described

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herein were intentional, or alternatively, made without the use of reasonable procedures adopted to avoid such an error.

115. Defendants and each of them, directly or indirectly, have engaged in substantially similar conduct toward Mr. Barkan and each Class Member.

116. Such wrongful actions and conduct are ongoing and continuing. Unless Defendants and each of them are enjoined from continuing to engage in such wrongful actions and conduct, the public will continue to be harmed by their conduct.

117. Defendants, and each of them, aided and abetted, encouraged, and rendered substantial assistance in accomplishing the wrongful conduct and their wrongful goals and other wrongdoing complained of herein. In taking action, as particularized herein, to aid and abet and substantially assist the commission of these wrongful acts and other wrongdoings complained of, each of the Defendants acted with an awareness of his/her/its primary wrongdoing and realized that his/her/its conduct would substantially assist the accomplishment of the wrongful conduct, wrongful goals, and wrongdoing.

118. Mr. Barkan and the Class are entitled to an injunction, pursuant to Civil Code section 1780, prohibiting Health Net from continuing to engage in the above-described violations of the CLRA.

119. Mr. Barkan and the Class Members are entitled to recover attorney fees and costs pursuant to Civil Code section 1780(d).

120. Mr. Barkan and the Class Members are also entitled to recover attorney fees pursuant to Code of Civil Procedure section 1021.5, as they are the catalyst for enforcement of important rights affecting the public interest that confer a significant benefit on the general public.

121. The conduct of defendants and each of them as alleged herein was fraudulent, oppressive and malicious, was carried out with a conscious disregard of Mr. Barkan and the Class Members' rights, and constitutes despicable conduct intended to vex, injure and annoy Mr. Barkan and the Class Members. Defendants and each of them are guilty of oppression, fraud and malice under Civil Code section 3294, entitling Mr. Barkan and the Class Members to punitive damages in an amount appropriate to punish defendants and deter others from engaging in similar wrongful

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conduct.

122. The conduct of defendants and each of them as alleged herein was undertaken by defendants' officers, directors or managing agents, identified herein as Does 1 through 100, who were responsible for supervision, operation, reports, communication and decisions. The conduct of said officers, directors and managing agents, and of other employees, representatives and agents, was undertaken on behalf of defendants, which had advance knowledge of the action and conduct of said individuals whose conduct and actions were authorized, ratified and approved by officers, directors or managing agents of defendants, whose precise identities are unknown to Mr. Barkan and the Class Members at this time and are therefore identified and designated herein as Does 1 through 100.

FIFTH CAUSE OF ACTION

Declaratory Relief

Against All Defendants

123. Mr. Barkan incorporates by reference each of the preceding paragraphs as though fully set forth herein.

124. California Code of Civil Procedure section 1060 provides that any person "interested under ... a contract ... may, in cases of actual controversy relating to the legal rights and duties of respective parties" bring an action in Superior Court for a declaration of his or her rights and that "the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time."

125. An actual controversy has arisen between Mr. Barkan and the Class Members he represents on the one hand, and defendants and each of them on the other hand, as to their respective rights and obligations under the health plan contracts between them. Specifically, Mr. Barkan and the Class Members seek a declaration, among other things, that:

a. The exclusion in the EOC for "Experimental or Investigational Services" is ambiguous and unenforceable;

b. The mandatory binding arbitration provision in the EOC does not comply with the Knox-Keene Act and is unenforceable; and

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c. The mandatory binding arbitration provision in the EOC is unconscionable and unenforceable.

126. Mr. Barkan and the Class Members are also entitled to recover attorney fees pursuant to Code of Civil Procedure section 1021.5, as they are the catalyst for enforcement of important rights affecting the public interest that confer a significant benefit on the general public.

PRAYER FOR RELIEF

Mr. Barkan, individually and on behalf of the Class Members, prays for judgment against defendants and each of them, and that the Court award the following relief:

1. An award for compensatory, general and special damages in amounts to be proven at trial;
2. For costs incurred in connection with this lawsuit;
3. For punitive damages;
4. For prejudgment interest;
5. For attorney's fees;
6. For equitable, injunctive and declaratory relief; and
7. For all other relief the Court deems just and proper.

JURY DEMAND

Mr. Barkan demands a trial by jury on all issues so triable.

Dated: June 29, 2018

CALLAHAN & BLAINE, APLC

By: _____

Daniel J. Callahan
Edward Susolik
Richard T. Collins
Damon D. Eisenbrey
Attorneys for Plaintiff Ohad Barkan, individually and on behalf of all others similarly situated

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Exhibit "A"

Exhibit "A"

A COMPLETE

explanation of your plan

For University of California non-Medicare members
Effective 1/1/2018

Evidence of Coverage
Health Net Blue & Gold
HMO
Plan DW7
EOCID:

Dear Health Net Member:

Thank you for choosing Health Net to provide your health care benefits. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

This is your new Health Net *Evidence of Coverage*.

If your Group has requested that we make it available, you can access this document online through Health Net's secure website at www.healthnet.com/uc. You can also elect to have a hard copy of this Evidence of Coverage mailed to you. Please call the telephone number on the back of your Member identification card to request a copy.

If you've got a web-enabled smartphone, you've got everything you need to track your health plan details. Take the time to download Health Net Mobile. You'll be able to carry your ID card with you, easily find details about your plan, store provider information for easy access, search for doctors and hospitals, or contact us at any time. It's everything you need to track your health plan details – no matter where you are as long as you have your smartphone handy.

We look forward to serving you. Contact us at www.healthnet.com/uc 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at one of the numbers below. Our Customer Contact Center is available from 7:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

Thank you for choosing Health Net.

Schedule changes in 2018

This page is not an official statement of benefits. Your benefits are described in detail in the *Evidence of Coverage*. We have also edited and clarified language throughout the *Evidence of Coverage* in addition to the items listed below.

1. Changes to this Plan

- **Notice of Language Services** – Updated to include more languages.

Note:
Once you enroll in Medicare, your behavioral health provider network will be different and you will need to obtain new authorizations/self referrals to behavioral health providers. Please review your Health Net ID card for the appropriate phone number for Mental Health and Substance Abuse.

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE HEALTH NET BLUE & GOLD HMO NETWORK HEALTH PLAN SERVICE AREA° AND OBTAINING SERVICES FROM HEALTH NET BLUE & GOLD HMO NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

Except for emergency care, benefits for Physician and Hospital services under this **Health Net HMO Network** ("Health Net Blue & Gold HMO Network") plan are only available when you live or work in the Health Net Blue & Gold Network service area° and use a Health Net Blue & Gold HMO Network Physician or Hospital. When you enroll in this Health Net Blue & Gold HMO Network plan, you may only use a Physician or Hospital who is in the Health Net Blue & Gold HMO Network and you must choose a Health Net Blue & Gold HMO Network Primary Care Physician (PCP). You may obtain ancillary or pharmacy covered services and supplies from any Health Net participating ancillary or pharmacy provider.

The Health Net Blue & Gold HMO Network is designed to offer you a full array of providers that are available to meet your health care needs. Your designated Blue & Gold HMO Network Physician and his or her Medical Group helps manage the utilization of your benefits by ensuring that referrals are directed to specialists and hospitals who are contracted with the Blue & Gold Network. Your Blue & Gold HMO Network Physician Group may also have special arrangements with certain hospitals within the Blue & Gold Network and designate a specific hospital as "in network." Health Net refers to this collectively as your "Physician Group Network."

A few Enrollees who, live or work in some remote or rural zip codes of the Health Net Blue & Gold Network service area, may need to travel up to or exceeding thirty miles for access to a Health Net Blue & Gold Network provider. You can confirm if the zip code where you live or work is affected by calling the telephone number on your Health Net identification card, or by logging on to www.healthnet.com/uc.

OBTAINING COVERED SERVICES UNDER THE HEALTH NET BLUE & GOLD HMO NETWORK PLAN

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY
AVAILABLE FROM	*Only Blue & Gold Network Hospitals	*Only Blue & Gold Network Physicians	All Health Net contracting ancillary providers	All Health Net participating pharmacies

* *The benefits of this plan for Physician and Hospital services are only available for covered services received from a Health Net Blue & Gold HMO Network Physician or Hospital, except for (1) urgently needed care outside a 30-mile radius of your Physician Group and all emergency care; (2) referrals to non-Health Net Blue & Gold HMO Network providers are covered when the referral is issued by your Health Net Blue & Gold HMO Network Physician Group; and (3) covered services provided by a non-Health Net Blue & Gold HMO Network provider when authorized by Health Net. Please refer to "Specialists and referral care" in the "How the plan works" section and "Emergencies" in the "Benefits and coverage" section for more information.*

The coinsurance percentage you pay is based on the negotiated rate with the treating provider. Health Net Blue & Gold HMO Network providers may or may not have lower rates than Health Net's full network providers, to whom you may be referred by your PCP or your Physician Group for these specific services

The service area and a list of Health Net Blue & Gold HMO Network Physician and Hospital providers are listed online at our website: www.healthnet.com/uc. A copy of the *Health Net Blue & Gold HMO Network Provider* listing may be ordered online or by calling Health Net Customer Contact Center at the phone number on the back cover.

Not all Physicians and Hospitals who contract with Health Net are Health *Net Blue & Gold HMO Network providers. Only those Physicians and Hospitals specifically identified as participating in the Health Net Blue & Gold HMO Network may provide services under this plan, except as described in the chart above.*

Unless specifically stated otherwise, use of the following terms in this Summary of benefits/disclosure form (SB/DF) solely refer to the Health Net Blue & Gold HMO Network as explained above.

- Health Net
- Health Net service area
- Hospital
- Member Physician, Participating Physician Group, Primary Care Physician, Physician, participating provider, contracting Physician Groups and contracting Providers
- Network

If you have any questions about the Health Net Blue & Gold HMO Network Service Area, choosing your Health Net Blue & Gold HMO Network Primary Care Physician, how to access specialist care or your benefits, please call Health Net Customer Contact Center at the phone number on the back cover.

About This /Booklet

Please read the following information so you will know from whom or what group of providers health care may be obtained.

This *Evidence of Coverage* constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Health Net ID Card, your Physician Group or your Primary Care Physician.

This is not a Federally Qualified Plan

"Not a Federally Qualified Plan due to the carve out of behavioral health services to Optum".

Use of Special Words

Special words used in this *Evidence of Coverage* (EOC) to explain your Plan have their first letter capitalized and appear in "Definitions," Section 9.

The following words are used frequently:

- **"You"** or **"Your"** refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- **"Employee"** has the same meaning as the word "you" above.
- **"We"** or **"Our"** refers to Health Net.
- **"Subscriber"** means the primary covered person, generally an Employee of a Group.
- **"Physician Group"** or "Participating Physician Group (PPG)" means the medical group the individual Member selected as the source of all covered medical care.
- **"Primary Care Physician"** is the individual Physician each Member selected who will provide or authorize all covered medical care.
- **"Group"** is the business entity (usually an employer or Trust) that contracts with Health Net to provide this coverage to you.
- **"Plan"** and ***"Evidence of Coverage"*** **"EOC"** have similar meanings. You may think of these as meaning your Health Net benefits.

Table of Contents

UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2018

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Employees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Complete Guide to Your UC Health Benefits". A copy of this booklet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees
Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees". A copy of this fact sheet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Miscellaneous Provisions

Extension of Benefits
When Benefits May Be Extended
Benefits may be extended beyond the date coverage would ordinarily end if you lose your Health Net coverage because the UC Standardized Contract is discontinued and you are ***totally disabled*** at that time. When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits and Copayments," Section 3, will continue to apply.

Benefits will only be extended for the condition that caused you to become totally disabled. Benefits will not be extended for other medical conditions.

Benefits will not be extended if coverage was terminated for cause. **"Totally disabled"** has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

- No extension will be granted unless Health Net receives written certification of such total disability from the Member's Contracting Physician Group within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Health Net.

How to Obtain an Extension
If your coverage ended because the UC Standardized Contract between Health Net and the Group was terminated, and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. No extension will be granted unless Health Net receives written certification of such total disability from the Member's Contracting Physician Group within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Health Net.

When the Extension Ends
The Extension of Benefits will end on the *earliest* of the following dates:

- On the date the Member is no longer totally disabled;
- On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
- On the date that available benefits are exhausted; or
- On the last day of the 12-month period following the date the extension began.

Optional Continuation of Coverage
As an enrollee in this Plan, you and/or your covered Family Members may be entitled to continue health care coverage if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your Family Members will have to pay for such coverage. You may direct questions about these provisions to the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor) or visit the website http://ucnet.universityofcalifornia.edu/employees/health_welfare/cobra.html.

Contract Termination
Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits incurred after the contract terminates. You may be entitled to continued benefits under terms which are specified elsewhere in this document.

Special Reinstatement Rule Under USERRA
USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

Effect of Medicare
If you are covered under a UC retiree group medical plan and eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. If you are a retiree becoming Medicare-eligible, you should contact the University's Customer Service Center to transfer to the Medicare version of your plan. Once you and/or a family member are transferred to the Medicare version of your plan, your prescription drug coverage will change to a Part D + UC Rx wrap plan. You will also be ineligible for mental health and chemical dependency benefits through Optum. Once you are enrolled in Medicare and transferred to the Medicare version of your plan, you should review your new Evidence of Coverage booklet for information on how to access behavioral health services and properly use your UC retiree Medicare plan benefits.

Transferring to Another Contracting Medical Group
As stated in the "Selecting a Contracting Physician Group" provision, each person must select a contracting Medical Group from our network. Each person must select a Contracting Medical Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

Any individual Member may change Medical Group that transfer from one to another:

- When the Group's Open Enrollment Period occurs;
- When the Member moves to a new address (notify Health Net within 30 days of the change);
- When the Member's employment work-site changes (notify Health Net within 30 days of the change);
- When determined necessary by Health Net; or
- When the Member exercises the once-a-month transfer option.

Newborn Child
A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child by the 30th day.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Contracting Physician Group. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Contracting Physician Group. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in "Transferring to Another Contracting Physician Group" portion of this section.

Exceptions
Health Net will not permit a once-a-month transfer at the Member's option, if the Member is confined to a Hospital. However, if you believe you should be allowed to transfer to another Contracting Physician Group because of unusual or serious circumstances, and you would like Health Net to give special consideration to your needs, please contact the Customer Contact Center at the telephone number on your Health Net ID Card for prompt review of your request.

Effective Date of Transfer
Once we receive your request for a transfer, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If your request for a transfer is not allowed because of a hospitalization and you still wish to transfer after the medical condition or treatment for it has ended, please call the Customer Contact Center to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following the date the treatment for the condition causing the delay ends.

For a newly eligible child who has been automatically assigned to a Contracting Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible.

In Hospital on Your Effective Date
If you are confined in a Hospital or Skilled Nursing Facility on the Effective Date of coverage, this Plan will cover the remainder of that confinement only if you inform the Customer Contact Center upon your Effective Date about the confinement.

Health Net and your selected Contracting Physician Group will consult with your attending Physician, and may transfer you to a participating facility when medically appropriate.

Totally Disabled on Your Effective Date
Generally, under the federal Health Insurance Portability and Accountability Act, Health Net cannot deny You benefits due to the fact that You are totally disabled on your Effective Date. However, if upon your Effective Date you are totally disabled and pursuant to state law you are entitled to an extension of benefits from your prior group health plan, benefits of this Plan will be coordinated with benefits payable by your prior group health plan, so that not more than 100% of covered expenses are provided for services rendered to treat the disabling condition under both plans.

For the purposes of coordinating benefits under this Evidence of Coverage, if you are entitled to an extension of benefits from your prior group health plan, and state law permits such arrangements, your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this Evidence of Coverage shall be considered the secondary plan (paying any excess covered expenses), up to 100% of total covered expenses.

2. INTRODUCTION TO HEALTH NET

How to Obtain Care

When you enroll in this Plan, you must select a contracting Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. For contact information on your Physician Group, please call the Customer Contact Center at the telephone number on your Health Net ID card.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Customer Contact Center at 1-800-539-4072 to ensure that you can obtain the health care services that you need.

Transition of Care For New Enrollees

You may request continued care from a provider, including a Hospital, that does not contract with Health Net if, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

1. An Acute Condition;
2. A Serious Chronic Condition not to exceed twelve months from your Effective Date of coverage under this Plan;
3. A pregnancy (including the duration of the pregnancy and immediate postpartum care);
4. A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
5. A Terminal Illness (for the duration of the Terminal Illness); or
6. A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

In addition, You may request continued care from a provider, including a Hospital, if you have been enrolled in another Health Net HMO plan that included a larger network than this plan, Health Net will offer the same scope of continuity of care for completion of services, regardless of whether You had the opportunity to retain Your current provider by selecting either:

7. a Health Net product with an out of network benefit;
8. a different Health Net HMO network product that included Your current provider; or
9. another health plan or carrier product.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions" section 9.

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's effective date, and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Assistance

Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID Card.

Selecting a Primary Care Physician

Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your Family Members, subject to the requirements set out below under "Selecting a Contracting Physician Group."

For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician and a list of the participating Primary Care Physicians in the Health Net Service Area are available on the Health Net website at www.healthnet.com/uc. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.

Selecting a Contracting Physician Group

Each person must select a Primary Care Physician at a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. Family Members may select different contracting Physician Groups.

Subscriber who resides outside the Health Net Service Area, may enroll based on the Subscriber's work address that is within the Health Net Service Area. Family Members who reside outside the Health Net Service Area may also enroll based on the Subscriber's work address that is within the Health Net Service Area. If you choose a Physician Group based on its proximity to the Subscriber's work address, you will need to travel to that Physician Group for any non-emergency or non-urgent care that you receive. Additionally, some Physician Groups may decline to accept assignment of a Member whose home or work address is not close enough to the Physician Group to allow reasonable access to care. Please call the Customer Contact Center at the number shown on your Health Net I.D. Card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.healthnet.com/uc.

Specialists and Referral Care

Sometimes, you may need care that the Primary Care Physician cannot provide. At such times, you will be referred to a Specialist or other health care provider for that care.

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

Standing Referral to Specialty Care for Medical and Surgical Services

A standing referral is a referral to a participating Specialist for more than one visit without your Primary Care Physician having to provide a specific referral for each visit. You may receive a standing referral to a Specialist if your continuing care and recommended treatment plan is determined Medically Necessary by your Primary Care Physician, in consultation with the Specialist, Health Net's Medical Director and you. The treatment plan may limit the number of visits to the Specialist, the period of time that the visits are authorized, or require that the Specialist provide your Primary Care Physician with regular reports on the health care provided. Extended access to a participating Specialist is available to Members who have a life threatening, degenerative or disabling condition (for example, Members with HIV/AIDS). To request a standing referral ask your Primary Care Physician or Specialist.

If you see a Specialist before you get a referral, you may have to pay for the cost of the treatment. If Health Net denies the request for a referral, Health Net will send you a letter explaining the reason. The letter will also tell you what to do if you don't agree with this decision. This notice does not give you all the information you need about Health Net's Specialist referral policy. To get a copy of our policy, please contact us at the number shown on your Health Net I.D. Card

Changing Contracting Physician Groups

As stated in Section "Using the plan's coverage for your medical services," each person must select a contracting Medical Group from our network. Each person must select a Contracting Medical Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

Any individual Member may change Medical Groups that is, transfer from one to another:

- When the Group's Open Enrollment Period occurs;
- When the Member moves to a new address (notify Health Net within 30 days of the change);
- When the Member's employment work-site changes (notify Health Net within 30 days of the change);
- When determined necessary by Health Net; or
- When the Member exercises the once-a-month transfer option.

You may transfer to another contracting Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 1.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Copayment described in "Schedule of Benefits and Copayments," Section 3.

You are completely financially responsible for medical care that the contracting Physician Group does not provide or authorize except for Medically Necessary care provided in a legitimate emergency. However, if you receive Covered Services at a contracted network health facility at which, or as a result of which, you receive services provided by a non-contracted provider, you will pay no more than the same cost sharing you would pay for the same Covered Services received from a contracted network provider. You are also financially responsible for care that this Plan does not cover.

Questions

Call the Customer Contact Center with questions about this Plan at the number shown on your Health Net ID Card.

Timely Access to Care

The California Department of Managed Health Care (DMHC) has new laws (California Code of Regulations, Title 28, Section 1300.67.2.2) requiring health plans to provide timely access to non-emergency Health Care Services.

Please contact Health Net at the number shown on your Health Net I.D. Card, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered Health Care Services in a timely manner.

Please see "Customer Contact Center Interpreter Services" in the "General Provisions" section, and the "Notice of Language Services" section, for information regarding the availability of no cost interpreter services.

Definitions Related to Timely Access to Care

Triage or Screening is the evaluation of a Member's health concerns and symptoms by talking to a doctor, nurse, or other qualified health care professional to determine the Member's urgent need for care.

Triage or Screening Waiting Time is the time it takes to speak by telephone with a doctor, nurse, or other qualified health care professional who is trained to screen or triage a Member who may need care , and will not exceed 30 minutes.

Business Day is every official working day of the week. Typically, a business day is Monday through Friday, and does not include weekends or holidays.

Scheduling Appointments

When you need to see your Primary Care Physician (PCP), call his or her office for an appointment. The phone number is on your ID card. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net Member, and tell the receptionist when you would like to see your doctor. The receptionist will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your Physician as soon as possible.

This is a general idea of how many business days you may need to wait to see your doctor. Wait times depend on your condition and the type of care you need. You should get an appointment to see your PCP:

- **PCP appointments:** within 10 business days of request for an appointment.
- **Urgent care appointment with PCP:** within 48 hours of request for an appointment.
- **Routine Check-up/Physical Exam:** within 30 business days of request for an appointment.

Your Physician may decide that it is okay to wait longer for an appointment as long as it doesn't harm your health.

Canceling Appointments If you cannot go to your appointment, call the doctor's office right away. By canceling your appointment, you let someone else be seen by the doctor.

Scheduling Appointments with a Specialist for Medical and Surgical Services

Your Primary Care Physician is your main doctor who makes sure you get the care you need when you need it. Sometimes your Primary Care Physician will send you to a Specialist.

Once you get approval to receive the Specialist services, call the Specialist's office to schedule an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net Member, and tell the receptionist when you would like to see the Specialist. The Specialist's office will do their best to make your appointment at a time that works best for you.

This is a general idea of how many business days, as defined above, that you may need to wait to see the Specialist. Wait times for an appointment depend on your condition and the type of care you need. You should get an appointment to see the Specialist:

- **Specialist appointments:** within 15 business days of request for an appointment.
- **Urgent care appointment:** with a Specialist or other type of provider that needs approval in advance – within 96 hours of request for an appointment.

Scheduling Appointments for Ancillary Services

Sometimes your doctor will tell you that you need ancillary services such as lab, x-ray, therapy, and medical devices, for treatment or to find out more about your health condition.

Here is a general idea of how many business days, as defined above, that you may need to wait for the appointment:

- **Ancillary Service appointment:** within 15 business days of request for an appointment.
- **Urgent care appointment for services that need approval in advance:** within 96 hours of request for an appointment.

Canceling or Missed Your Appointment

If you miss your appointment, call right away to make another appointment.

Sometimes your doctor will tell you that you need ancillary services such as lab, x-ray, therapy, and medical devices, for treatment or to find out more about your health condition. Here is a general idea of how many business days you may need to wait for the appointment:

Triage and/or Screening/24-Hour Nurse Advice Line

As a Health Net Member, when you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the Triage and/or Screening option to these services. You'll be connected to a health care professional (doctor, nurse, or other providers depending on your needs) who will be able to help you and answer your questions. As a Health Net Member, you have access to triage or screening service, 24 hours per day, 7 days per week.

If you have a life threatening emergency, call "911" or go immediately to the closest emergency room. Use "911" only for true emergencies.

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

In serious emergency situations: Call **"911"** or go to the nearest Hospital.

If your situation is not so severe: Call your Primary Care Physician or Physician Group or, if you cannot call them or you need medical care right away, go to the nearest medical center or Hospital.

Your Physician Group and Behavioral Health Administrator are available 24 hours a day, seven days a week, to respond to your phone calls regarding care that you believe is needed immediately. They will evaluate your situation and give you directions about where to go for the care you need.

Except in an emergency or other urgent medical circumstances, the covered services of this Plan must be performed by your Physician Group or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group.

If you are not sure whether you have an emergency or require urgent care please contact Health Net at the number shown on your Health Net I.D. card. As a Health Net Member, you have access to triage or screening services, 24 hours per day, 7 days per week.

Urgently Needed Care within a 30-mile radius of your Physician Group and all Non-Emergency Care must be performed by your Physician Group or authorized by them in order to be covered. These services, if performed by others outside your Physician Group, will not be covered unless they are authorized by your Physician Group.

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care (including care outside of California)— may be performed by your Physician Group or another provider when your circumstances require it. Services by other providers will be covered if the facts demonstrate that you required Emergency or Urgently Needed Care. Authorization is not mandatory to secure coverage. See the "Definitions Related to Emergency and Urgently Needed Care" section below for the definition of Urgently Needed Care.

It is critical that you contact your Physician Group as soon as you can after receiving emergency services from others outside your Physician Group. Your Physician Group will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care. They will also advise you about how to obtain reimbursement for charges you may have paid.

Always present your Health Net ID Card to the health care provider regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician Group.

After your medical problem no longer requires Urgently Needed Care or ceases to be an emergency and your condition *is stable, any additional care you receive is considered Follow-Up Care.*

***Follow-Up Care** services must be performed or authorized by your Physician Group (medical) or it will not be covered.*

Continuing or Follow-up Care after Emergency Care at a Hospital that is not affiliated with your Health Net Physician Group: *If you are treated for Emergency Care at a Hospital that is not part of your Physician Group Network, once your Emergency medical condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the Hospital must contact Health Net to obtain timely authorization. Follow-up Care must be authorized by Health Net or it will not be covered. If Health Net determines that you may be safely transferred to a Hospital that is part of your Health Net Physician Group Network and you refuse to consent to the transfer, the Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your Emergency condition is stable. Also, if the Hospital is unable to determine the contact information at Health Net in order to request prior authorization, the Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan hospital, you should contact Health Net at the telephone number on your identification card.*

Definitions Related To Emergency And Urgently Needed Care

Please refer to "Definitions," Section 900, for definitions of Emergency Care, Emergency Medical Condition, Psychiatric Emergency Medical Condition and Urgently Needed Care.

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the drug less any required Copayment shown in "Schedule of Benefits and Copayments," Section 3. You will have to pay for the Prescription Drug when it is dispensed.

To be reimbursed, you must file a claim with Health Net. Call the Customer Contact Center at the telephone number on your Health Net ID Card or visit our website at www.healthnet.com/uc to obtain claim forms and information.

Note

The Prescription Drugs portion of "Exclusions and Limitations," Section 6, and the requirements of the Commercial Formulary also apply when drugs are dispensed by a Nonparticipating Pharmacy.

Chiropractic Services

If you require Emergency Chiropractic Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Chiropractic Services are covered services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal which manifests itself by acute symptoms of sufficient severity, including severe Pain, person could reasonably expect that a delay of immediate Chiropractic Services could result in any of the serious jeopardy to your health or body functions or organs. See also "Definitions," Section 900, "Emergency Chiropractic Services."

ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

You may receive Emergency Chiropractic Services from any chiropractor. ASH Plans will not cover any services as Emergency Chiropractic Services unless the chiropractor rendering the services can show that the services in fact were Emergency Chiropractic Services. You must receive all other covered Chiropractic Services from a chiropractor under contract with ASH Plans ("Contracted Chiropractor") or from a non-Contracted Chiropractor only upon a referral by ASH Plans.

Because ASH Plans arranges only Chiropractic Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling **"911."** You are encouraged to use appropriately the **"911"** emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

Acupuncture Services

If you require Emergency Acupuncture Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Acupuncture Services are covered Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal

system, or causing Pain or Nausea which manifests itself by acute symptoms of sufficient severity, person, could reasonably expect that a delay of immediate Acupuncture Services could result in serious jeopardy to your health or body functions or organs. See also "Definitions," Section 900, "Emergency Acupuncture Services."

ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

You may receive Emergency Acupuncture Services from any acupuncturist. ASH Plans will not cover any services as Emergency Acupuncture Services unless the acupuncturist rendering the services can show that the services in fact were Emergency Acupuncture Services. You must receive all other covered Acupuncture Services from an acupuncturist under contract with ASH Plans ("Contracted Acupuncturist") or from a non-Contracted Acupuncturist only upon a referral by ASH Plans.

Because ASH Plans arranges only Acupuncture Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling **"911."** You are encouraged to use appropriately the **"911"** emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

3. SCHEDULE OF BENEFITS AND COPAYMENTS

The following schedule shows the Copayments (fixed dollar and percentage amounts) that you must pay for this Plan's covered services and supplies.

You must pay the stated fixed dollar Copayments at the time you receive services. Percentage Copayments are usually billed after services are received

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to "Out-of-Pocket Maximum," Section 4, for more information.

The University of California has independently contracted with Optum , a specialized health care service plan, to provide Mental Health and Substance Abuse services. Refer to "Mental Health and Substance Abuse services" outlined in this Section 3.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center

	Copayment
Use of emergency room (facility and professional services)	$75
Use of urgent care center (facility and professional services)	$20

Copayment Exceptions

- If you are admitted to a Hospital as an inpatient directly from the emergency room or urgent care center, the emergency room or urgent care center Copayment will not apply.

Office Visits

	Copayment
Visit to Physician, Physician Assistant, or Nurse Practitioner at a contracting Physician Group	$20
Specialist or specialty care consultation	$20
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$20
Vision or hearing examination (for diagnosis or treatment)	$20

Notes

Self-referrals are allowed for obstetrician, gynecological services, and reproductive and sexual health care services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" and "Self-Referral for Reproductive and Sexual Health Care Services" portions of "Covered Services and Supplies," Section 5.)

Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

Mental Health and Substance Abuse services are not included.

Preventive Care Services

	Copayment
Preventive Care Services	$0

Notes

Covered services include, but are not limited to, annual preventive physical examinations, immunizations, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support and supplies and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of "Covered Services and Supplies," Section 5 for details.

If you receive any other covered services in addition to Preventive Care Services during the same visit, you will also pay the applicable Copayment for those services.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Note:

The above Copayment applies to professional services only. Care that is rendered in a Hospital is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" heading to determine any additional Copayments that may apply.

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$20
Allergy injection services	$20
Allergy serum	$0
Immunizations for occupational purposes or foreign travel	$0
Injections (except for Infertility) Office based injectable medications (per dose)	$20

Notes

Immunizations that are part of Preventive Care Services are covered under "Preventive Care Services" in this section.

Injections for the treatment of Infertility are described below in the "Infertility Services" section.

**Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If you need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through our contracted Specialty Pharmacy Vendor and bring it with you to the Physician's office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted Specialty Pharmacy Vendor or University of California Pharmacy. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits and Copayments" section for the applicable Copayment.

Rehabilitation Therapy

	Copayment
Physical therapy	$20
Occupational therapy	$20
Speech therapy	$20
Pulmonary rehabilitation therapy	$20
Cardiac rehabilitation therapy	$20

Notes

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation Therapy" of "Exclusions and Limitations," Section 6.

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$0
Physician visit to the mother or newborn at a Hospital	$0
Normal delivery, including cesarean section	$0
Complications of pregnancy, including Medically Necessary abortions**	See note below
Elective abortion in Contracting Physician Group's office	$0
Elective abortions in Hospital	$0
Genetic testing of fetus	$0

Circumcision of newborn (birth through 30 days)* $0

Notes

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full. See "Preventive Care Services" above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" under "Covered Services and Supplies," Section 5.

* Circumcisions for Members age 31 days and older are covered when Medically Necessary under outpatient surgery. Refer to "Other Professional Services" and "Outpatient Hospital Services" for applicable Copayments.

**Applicable Copayment or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment or coinsurance will apply.

Family Planning

	Copayment
Sterilization of females in Contracting Physician Group's office	$0
Sterilization of females in Hospital	$0
Sterilization of males in Contracting Physician Group's office	$20
Sterilization of males in Hospital	$0
Contraceptive devices (including but not limited to intrauterine devices (IUD) and Depo Provera injections)	$0
Injectable contraceptives (including but not limited to Depo Provera)	$20

Notes

The diagnosis, evaluation and treatment of Infertility are described below in the "Infertility Services" section.

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

Infertility Services

	Copayment
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	50%

Notes

Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections.

Infertility services (which include GIFT) and all covered services that prepare the Member to receive this procedure, are covered only for the Health Net Member.

Injections for Infertility are covered only when provided in connection with services that are covered by this Plan.

Refer to the "Family Planning" provision in "Covered Services and Supplies," Section 5 and the "Conception by Medical Procedures," provision of "Exclusions and Limitations," Section 6 for additional information.

If one partner does not have Health Net coverage, Infertility services are covered only for the Health Net Member.

Other Professional Services

	Copayment
Surgery performed in a Contracting Physician Group's office	$20

Surgery	$0
Assistance at surgery performed in a Contracting Physician Group's office	$20
Assistance at surgery	$0
Administration of anesthetics	$0
Chemotherapy	$0
Radiation therapy	$0
Laboratory services	$0
Diagnostic imaging (including x-ray) services	$0
CT, SPECT, MRI, MUGA and PET	$0
Medical social services	$0
Patient education*	$0
Nuclear medicine (use of radioactive materials)	$0
Renal dialysis	$0
Organ, tissue, or stem cell transplants	$0

Notes

The above Copayments apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply.

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.

*Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care and have no cost-sharing; however, if other medical services are provided at the same time that are not solely for the purpose of covered health education counseling, the appropriate related Copayment will apply.

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers (including face masks and tubing)	$0
Orthotics (such as bracing, supports and casts)	$0
Diabetic equipment*	$0
Diabetic footwear	$0
Corrective Footwear (for the treatment of conditions not related to diabetes)**	$0
Prostheses (internal or external)	$0
Blood or blood products except for drugs used to treat hemophilia, including blood factors***	$0
Drugs for the treatment of hemophilia (up to a 30 day maximum per prescription)***	$20
Hearing Aids)	50%

Limitation

The Hearing aids Copayment will apply toward the purchase of the hearing aid. Hearing aids are covered to a maximum payment of $2000 for 2 devices every 36 months. Coverage includes repair and maintenance of the hearing aid at no additional charge. The initial hearing exam and fitting are also subject to the vision or hearing examination Copayment. Look under "Office Visits" heading in this "Schedule of Benefits and Copayments" section, to determine any additional Copayment that may apply. Additional charges for batteries (including the first set) or other equipment related to the hearing aid, or replacement of the hearing aid are not covered

Notes

*For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in "Covered Services and Supplies," Section 5

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section. For additional information, please refer to the "Preventive Care Services" provision in "Covered Services and Supplies," Section 5.

**Corrective Footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary.

***Drugs for the treatment of hemophilia are considered self-injectable drugs and covered as Specialty Drug under the Prescription Drug benefit.

Home Health Care Services

	Copayment
Home health visits	$0

Hospice Services

	Copayment
Hospice care	$0

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$250

Note

The above Copayments apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments that may apply.

Inpatient care for Infertility is described above in the "Infertility Services" section.

The above Copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Copayment for inpatient Hospital services for the newborn patient will apply.

Mental Health and Substance Abuse services are not included.

Outpatient Facility Services

Outpatient facility services (other than surgery)	$0
Outpatient surgery (surgery performed in a Hospital or Outpatient Surgical Center only)	$100

Notes

The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments. Look under the "Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional Copayments that may apply.

Outpatient care for Infertility is described above in the "Infertility Services" section.

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services, or physical therapy, are subject to the same Copayment which is required when these services are performed at your Physician's office.

Look under the headings for the various services such as office visits, neuromuscular rehabilitation, and other professional services to determine any additional Copayments that may apply.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment applicable for outpatient facility services.

Use of a Hospital emergency room appears in the first item at the beginning of this section.

Mental Health and Substance Abuse services are not included.

Skilled Nursing Facility Services

	Copayment
Room and board in a semi private room with ancillary (additional) services	$0

Limitation

Skilled Nursing Facility services are covered for up to a maximum of 100 days a Calendar Year for each Member.

Prescription Drug Benefits

	Copayment
Retail Pharmacy (up to a 30 day supply)	
Tier 1 include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary	$5
Tier 2 include non-preferred, Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Commercial Formulary	$25
Tier 3 include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 in the Commercial Formulary, drugs indicated as "NF", if approved, or drugs not listed in the Commercial Formulary)	$40
Lancets	$0
Sexual dysfunction drugs (including self-injectable drugs)	50%
Appetite Suppressants	50%
Oral Infertility drugs	50%
Preventive drugs and women's contraceptives	$0
Insulin	$25

The Tier 2 Brand Name Drug Copayment will be applicable for all covered Diabetic Supplies.

Insulin needles and syringes will be dispensed in the amount required by your Physician for a 30-day period. You must pay one Copayment for the 30-day supply.

Blood Glucose monitoring test strips and lancets will be dispensed in 50-unit, 100-unit or 200-unit packages for each 30-day period. You must pay one Copayment for each package.

*Members are required to pay the difference between a brand-name and a generic drug plus the generic copay, when the generic is available. (Exceptions for medical necessity are available via prior authorization, if approved, the applicable brand copay applies.)

Specialty Drugs (up to a 30 day supply)

Except as listed below, all Specialty Drugs are subject to the applicable Tier 1, 2 or 3 Copayment shown above under "Retail Pharmacy".

Self-injectable drugs and drugs for the treatment of hemophilia, including blood factors, per prescription for a. maximum of 30 days per prescription.....$20

UC Walk-Up Service through UC Medical Center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC designated Medical Center pharmacies.

Maintenance Drugs through the Mail Order Program (up to a 90 day supply)

Tier 1 include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary. $10
Tier 2 (include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary.....$50
Tier 3 include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 in the Commercial Formulary, drugs indicated as "NF", if approved, or drugs not listed in the Commercial Formulary).....$80
Preventive drugs and women's contraceptives $0

Notes:

Orally administered anti-cancer drugs will have a Copayment maximum of $200 for an individual prescription of up to a 30-day supply.

For information about Health Net's Commercial Formulary, please call the Customer Contact Center at the telephone number on your ID card.

Percentage Copayments will be based on Health Net's contracted pharmacy rate or the pharmacy's retail price for covered Prescription Drugs.

Maintenance Drugs on the Health Net Maintenance Drug List may be obtained at a CVS retail pharmacy or a UC Walk-Up pharmacy under the mail order program benefits.

Generic Drugs will be dispensed when a Generic Drug equivalent is available unless a Brand Name Drug is specifically requested by the Physician or the Member, subject to the Copayment requirements specified in the "Copayment Exceptions" provision below.

You will be charged a Copayment for each Prescription Drug Order.

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portion of "Covered Services and Supplies" and the "Exclusions and Limitations" sections.

Prior Authorization

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Services and Supplies" Section 500 for a description of Prior Authorization requirements or visit our website at www.healthnet.com/uc to obtain a list of drugs that require Prior Authorization.

Copayment Exceptions:

If the pharmacy's or mail order administrator's retail price is less than the applicable Copayment, you will only pay the pharmacy's retail price or the mail order administrator's retail price.

If a Brand Name Drug is dispensed and its Generic Drug equivalent is covered as a Tier 1 or Tier 2 Drug, then you must pay the following:

- The Tier 1 Drug Copayment, plus
- The difference between the cost of the Generic Drug and the Brand Name Drug

However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed subject to as required for Brand Name Drugs and the following:

- The Tier 2 Drug Copayment for Tier 2 Drugs; or
- The Tier 3 Drug Copayment, for Tier 3 drugs.
- The difference between the cost of the Generic Drug and the Brand Name Drug

Preventive Drugs and Women's Contraceptives:

Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Please see the "Preventive Drugs and Women' Contraceptive" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 500, for additional details. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

If a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the Generic and Brand Name Drug. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order

Mail Order:

A 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

Diabetic Supplies:

Diabetic supplies (blood glucose testing strips, lancets, disposable needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., opened in order to dispense the product in quantities other than those packaged).

When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for up to a 30-day period.

Sexual Dysfunction Drugs

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited up to 8 doses per month as specified in the Health Net's Commercial Formulary.. For information about Health Net's Commercial Formulary after Health Net has provided the authorization, please call the Customer Contact Center at the telephone number on your ID card. Sexual dysfunction drugs are not available through the mail order program.

Chiropractic Services and Supplies

Chiropractic services and supplies are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you may obtain chiropractic care by selecting a Contracted Chiropractor from our *ASH Plans Contracted Chiropractor Directory*.

Office Visits	***Copayment***
New patient examination	$20
Each subsequent visit	$20
Re-examination visit	$20
Second opinion	$20

Note

If the re-examination occurs during a subsequent visit, only one Copayment will be required.

Limitations

Up to 24 Medically Necessary office visits to a Contracted Chiropractor during a Calendar Year are covered (combined with office visits to the Contracted Acupuncturist).

A visit to a Contracted Chiropractor to obtain a second opinion generally will not count toward the Calendar Year visit limit if you were referred by another Contracted Chiropractor. However, the visit to the first Contracted Chiropractor will count toward the Calendar Year visit limit.

Diagnostic Services	***Copayment***
X-rays	$0
Laboratory test	$0

Chiropractic Appliances	***Calendar year maximum***
For appliances	$50

Limitation

Up to a maximum of $50 is covered for each Member during a Calendar Year for covered Chiropractic Appliances.

Acupuncture Services

Acupuncture Services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a Contracted Acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*.

Office Visits	***Copayment***
New patient examination	$20
Each subsequent visit	$20
Re-examination visit	$20
Second opinion	$20

Note

If the re-evaluation occurs during a subsequent visit, only one Copayment will be required.

Limitations

Up to 24 office visits to a Contracted Acupuncturist during a Calendar Year are covered (combined with office visits to the Contracted Chiropractor).

A visit to a Contracted Acupuncturist to obtain a second opinion generally will not count toward the Calendar Year visit limit if you were referred by another Contracted Acupuncturist. However, the visit to the first Contracted Acupuncturist will count toward the Calendar Year visit limit.

Mental Health and Substance Abuse Services

University of California has independently contracted with Optum, a specialized health care service plan, to provide Mental Health and Substance Abuse services. Covered Services may be obtained by receiving a referral through Optum at **1-888-440-UCAL(8225)**. Care must be provided by an Optum participating provider and approved by Optum. Special provisions apply in the event of an emergency, and are described in detail in the Optum Evidence of Coverage (EOC).

Additional Benefits are provided for those Members having a diagnosis categorized as Severe Mental Illness. Please contact Optum at **1-888-440-UCAL (8225)** for a complete schedule of your Mental Health and Substance Abuse services.

4. OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for covered services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Copayments you pay for covered services under this *Evidence of Coverage*, including covered services and supplies provided by Optum, American Specialty Health Plans of California, Inc. (ASH Plans) and Prescription Drug benefits, in any one Calendar Year, equals the "Out-of-Pocket Maximum" amount, no payment for covered services and benefits may be imposed on any Member, except as described in "Exceptions to OOPM" below.

The OOPM amounts for this plan, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans) and Prescription Drug benefits are:

One Member $1,000

Two Members $2,000

Family (three or more Members) $3,000

Exceptions to OOPM

Your payments for services or supplies that this Plan does not cover will not be applied to the OOPM amount.

How the OOPM Works

Keep a record of your payment for covered medical services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the Customer Contact Center at the telephone number shown on your Health Net ID Card for instructions.

- If an individual Member pays amounts for covered services in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.
- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net, and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the Family OOPM

You must notify Health Net when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for payments for Covered Services as proof of Copayments made.

5. COVERED SERVICES AND SUPPLIES

You are entitled to receive Medically Necessary services and supplies described below when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

Any covered service or supply may require a Copayment or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 3, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 6, before obtaining care.

Medical Services and Supplies

Office Visits

Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals when you are referred by your Primary Care Physician.

Preventive Care Services s

The coverage described below shall be consistent with the requirements of the Affordable Care Act (ACA)

Preventive Care Services are covered for children and adults, as directed by your Physician, based on the guidelines from the following resources:

- U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (http://www.cdc.gov/vaccines/schedules/index.html)
- Guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services is available through www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF and Health Resources and Services Administration (HRSA) recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, , screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies

- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the Member. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by Your Physician. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number on your Health Net ID card

Preventive Care Services are covered as shown in the "Schedule of Benefits and Copayments" Section 2.

Vision and Hearing Examinations

Eye and ear examinations to determine the need for correction of vision and hearing are covered. Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge. Preventive vision and hearing screening are covered as Preventive Care Services.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

If you are a female Member you may obtain OB/GYN Physician services without first contacting your Primary Care Physician.

If you need OB/GYN preventive care, are pregnant, or have a gynecology ailment, you may go directly to an OB/GYN Specialist or a Physician who provides such services in your Physician Group.

If such services are not available in your Physician Group, you may go to one of the contracting Physician Group's referral Physicians who provides OB/GYN services. (Each contracting Physician Group can identify its referral Physicians.)

The OB/GYN Physician will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for Follow-Up Care.

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 3. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 3.

The coverage described above meets the requirements of the Affordable Care Act (ACA), which states:

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Customer Contact Center at the phone number on your Health Net ID card.

Self-Referral for Reproductive and Sexual Health Care Services

You may obtain reproductive and sexual health care Physician services without first contacting your Primary Care Physician. Reproductive and sexual health care services include:

- Counseling services;
- Prevention or treatment of pregnancy;
- Diagnosis or treatment of condition and medical evidence regarding an alleged rape or sexual assault; and
- HIV testing.

If you need reproductive or sexual health care services, you may go directly to a reproductive and sexual health care Specialist or a Physician who provides such services in your Physician Group.

If such services are not available in your Physician Group, you may go to one of the contracting Physician Group's referral Physicians who provides reproductive and sexual health care services. (Each contracting Physician Group can identify its referral Physicians.)

The reproductive and sexual health care Physician will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for Follow-Up Care.

Prenatal care, longer-term services, fertility services, and other sexual or reproductive services beyond the scope of the above listed services are not eligible for self-referral except as noted in the "Obstetrician and Gynecologist (OB/GYN) Self-Referral" provision above.

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 200. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 200.

Immunizations and Injections

This Plan covers immunizations and injections (including infusion therapy when administered by a health care professional in the office setting), professional services to inject the medications and the medications that are injected. This includes allergy serum. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 2.

In addition, injectable medications approved by the FDA to be administered by a health care professional in the office setting are covered.

You will be charged the appropriate Copayment as shown in "Schedule of Benefits and Copayments," Section 3.

Surgical Services

Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered.

Surgically Implanted Drugs

Surgically implanted drugs are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

Gender Reassignment Surgery

Medically Necessary gender reassignment services, including, but not limited to, psychotherapy, pre-surgical and post-surgical hormone therapy, and surgical services (such as, genital surgery and mastectomy), for the treatment of gender dysphoria or gender identity disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender reassignment surgery or a documented gender reassignment surgery treatment plan.

Reasonable travel, lodging and meal costs, as determined by Health Net, for a Covered Person to undergo an authorized gender reassignment surgery are covered. Travel and lodging are only available for the patient (companion not covered).

If you live 50 miles or more from the nearest authorized gender reassignment surgery facility, you are eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Member and for the prior approved gender reassignment surgery. All requests for travel expense reimbursement must be prior approved by Health Net.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the gender reassignment surgery facility up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Member not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net.

Laboratory and Diagnostic Imaging (including X-ray) Services
Laboratory and diagnostic imaging (including x-ray) services and materials are covered.

Home Visit
Visits by a Member Physician to a Member's home are covered at the Physician's discretion in accordance with the rules and criteria set by Health Net, and if the Physician concludes that the visit is medically and otherwise reasonably indicated.

Rehabilitation Therapy
Rehabilitation therapy services (physical, speech, and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 6.

Cardiac Rehabilitation Therapy
Rehabilitation therapy services provided in connection with the treatment of heart disease is covered when Medically Necessary.

Clinical Trials
Routine patient care costs for items and services furnished in connection with participating in an approved clinical trial are covered when Medically Necessary, authorized by Health Net. and either the Member's treating Physician has recommended participation in the trial or Member has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by non-participating providers are covered only when the protocol for the trial is not available through a participating provider. Services rendered as part of a clinical trial may be provided by a non-Participating or Participating Provider subject to the reimbursement guidelines as specified in the law.

The following definitions apply to the terms mentioned in the above provision only.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- A cooperative group or center of any of the entities described above; or
- The FDA as an Investigational new drug application;

"Life threatening condition" means any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted.

"Routine patient care costs" are the costs associated with the requirements of Health Net, including drugs, items, devices, and services that would normally be covered under this *Evidence of Coverage*, if they were not provided in connection with a clinical trials program.

Please refer to the "All Services and Supplies" portion of the Exclusions and Limitations

section for more information.

Pulmonary Rehabilitation Therapy
Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered. Please refer to "Schedule of Benefits and Copayments," Section 3, for Copayment requirements.

As an alternative to a Hospital setting, birthing center services are covered when authorized by your Physician Group. A birthing center is a homelike facility accredited by the Commission for Accreditation of Birth Centers (CABC) that is equipped, staffed and operated to provide maternity-related care, including prenatal, labor, delivery and postpartum care. Services provided by other than a CABC-accredited designated center will not be covered.

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service are covered as Preventive Care Services.

When you give birth to a child in a Hospital, you are entitled to coverage of at least 48 hours of care following a vaginal delivery, or at least 96 hours following a cesarean section delivery.

Your Physician will not be required to obtain authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital will require authorization. Also the performance of cesarean sections must be authorized.

You may be discharged earlier only if you and your Physician agree to it.

If you are discharged earlier, your Physician may decide, at his or her discretion, that you should be seen at home or in the office within 48 hours of the discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care. Your Physician will not be required to obtain authorization for this visit.

The coverage described above meets requirements for Hospital length of stay under the **Newborns' and Mothers' Health Protection Act of 1996**, which states:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Family Planning

This Plan covers counseling and planning for contraception or problems of fertility, fitting examination for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and women's contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Prescribed contraceptives for women are covered as described in the "Prescription Drugs" portion of this "Covered Services and Supplies" section of this *Evidence of Coverage*.

Infertility services (including artificial insemination procedures, office visits, follicle ultrasounds and sperm washing) gamete intrafallopian transfer (GIFT) and supplies are also covered as shown under "Infertility Services" in the Schedule of Benefits and Copayments," Section 2, but there are significant exclusions. Please refer to the "Conception by Medical Procedures" portion of "Exclusions and Limitations," Section 6 for more information.

This Plan also covers Medically Necessary services and supplies for established fertility preservation treatments, when treatment for cancer or gender dysphoria may directly or indirectly cause iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures. This benefit is subject to the applicable Copayments shown in "Schedule of Benefits and Copayments," Section 3, as would be required for covered services to treat any illness or condition under this Plan.

Medical Social Services
Hospital discharge planning and social service counseling are covered. In some instances, a medical social service worker may refer you to other providers for additional services. These services are covered only when authorized by your Physician Group and not otherwise excluded under this Plan.

Patient Education
Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered. Your Physician Group will coordinate access to these services.

Home Health Care Services
The services of a Home Health Care Agency in the Member's home are covered when provided by a registered nurse or licensed vocational nurse and /or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services must be ordered by your Physician, approved by your Physician Group or Health Plan and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Member is home bound because of illness or injury (this means that the Member is normally unable to leave home unassisted, and, when the Member does leave home, it must be to obtain medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Member's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See "Definitions," Section 9. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

Custodial Care services and Private Duty Nursing, as described in "Definitions," Section 9 and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See "Definitions," Section 9.

Ambulance Services
All air and ground ambulance, and ambulance transport services provided as a result of a **"911"** emergency response system request for assistance will be covered, if the criteria for Emergency Care, as defined in this *Evidence of Coverage*, have been met.

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible and they must authorize the services.

Please refer to the "Ambulance Services" provision of "Exclusions and Limitations," Section 6 for additional information.

Hospice Care

Hospice care is available for Members diagnosed as terminally ill by a Member Physician and the contracting Physician Group. To be considered terminally ill, a Member must have been given a medical prognosis of one year or less to live.

Hospice care includes Physician services, counseling, medications, other necessary services and supplies, and homemaker services. The Member Physician will develop a plan of care for a Member who elects Hospice care.

In addition, up to five consecutive days of inpatient care for the Member may be authorized to provide relief for relatives or others caring for the Member.

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Member.

Corrective Footwear (including specialized shoes, arch supports, and inserts) is covered when as Medically Necessary and custom made for the Member.

Corrective Footwear for the management and treatment of diabetes related medical conditions is covered under the "Diabetic Equipment" benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health Net applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Tier 2 and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage.

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and Orthotics are not subject to such quantity limits.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of "Exclusions and Limitations," Section 6. Please refer to "Schedule of Benefits and Copayments," Section 2 for the applicable Copayment.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the "Preventive Care Services" provision in this "Covered Services and Supplies" section.

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*
- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin, including pen needles*
- Specific brands of insulin syringes**

*These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the "Prescription Drugs" portion of this section for additional information.

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunization and Injections" portion of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" portion of this section for more information.

Hearing Aids

Standard hearing devices (analog or digital), which typically fit in or behind the outer ear, used to restore adequate hearing to the Member and determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to "Schedule of Benefits and Copayments," Section 3 for more information.

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. .

Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your Member Physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon.

If you live 50 miles or more from the nearest Health Net Bariatric Surgery Performance Center, you are eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Member and for the prior approved Bariatric weight loss surgery. All requests for travel expense reimbursement must be prior approved by Health Net.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit; the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Member) to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of three (3) trips (work-up visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Member not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Member) not to exceed $100 per day, up to four (4) days for the Member's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net.

Organ, Tissue, and Stem Cell Transplants

Organ, tissue, and stem cell transplants that are not Experimental or Investigational are covered if the transplant is authorized by Health Net and performed at a Health Net Transplant Performance Center.

Health Net has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Member Physician can provide you with information about our Transplant Performance Centers. You will be directed to a designated Health Net Transplant Performance Center at the time authorization is obtained.

Medically Necessary services, in connection with an organ, tissue or stem cell transplant are covered as follows:

- For the enrolled Member who receives the transplant; and
- For the donor (whether or not an enrolled Member). Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered.

Evaluation of potential candidates is subject to prior authorization. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is Medically Necessary.

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donation, including how to elect to be an organ donor, please contact the Customer Contact Center at the telephone number on your Health Net ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

Renal Dialysis

Renal dialysis services in your home service area are covered. Dialysis services for Members with end-stage-renal disease (ESRD) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of your home service area must be arranged and authorized by your Physician Group or Health Net in order to be performed by providers in your temporary location. Outpatient dialysis received out of the United States is not a covered service.

Prostheses

Internal and external prostheses required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, devices to restore speaking after a laryngectomy and visual aids (excluding Eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

Prostheses to restore symmetry after a Medically Necessary mastectomy (including lumpectomy), and prostheses to restore symmetry and treat complications, including lymphedema are covered. Lymphedema wraps and garments are covered, as well as up to three brassieres in a 12 month period to hold a prostheses.

In addition, enteral formula for members who require tube feeding is covered in accordance with Medicare guidelines.

Health Net or the Member's Physician Group will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, Health Net or the Physician Group will determine which device or appliance will be covered. The device must be among those that the Food and Drug Administration has approved for general use.

Prostheses will be replaced when no longer functional. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to replace or repair an item.

Prostheses are covered as shown under "Medical Supplies" in "Schedule of Benefits and Copayments," Section 2.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. However, self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group has authorized and scheduled.

Inpatient Hospital Confinement

Covered services include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary
- Physician services
- Specialized and critical care
- General nursing care
- Special duty nursing as Medically Necessary);
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services,
- Durable Medical Equipment and supplies;
- Medical social services
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Outpatient Hospital Services

Professional services, outpatient Hospital facility services and outpatient surgery performed in a Hospital or Outpatient Surgical Center are covered.

Professional services performed in the outpatient department of a Hospital (including but not limited to a visit to a Physician, rehabilitation therapy including physical, occupational, and speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, laboratory tests, x-ray, radiation therapy and chemotherapy) are subject to the same Copayment which is required when these services are performed at your Physician Group.

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than Copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Hospital Services" in "Schedule of Benefits and Copayments," Section 3, of this *Evidence of Coverage* for more information.

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following:

- Improve function; or
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 6. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies (including lumpectomies) and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

*The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the **Women's Health and Cancer Rights Act of 1998.** In compliance with the Women's Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also "Prostheses" in this "Covered Services and Supplies" section for a description of coverage for prostheses.*

Skilled Nursing Facility

Care in a room of two or more is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is Medically Necessary.

A Member does not have to have been hospitalized to be eligible for Skilled Nursing Facility care.

Benefits are limited to the number of days of care stated in "Schedule of Benefits and Copayments," Section 3.

Phenylketonuria (PKU)

Coverage for testing and treatment of phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs, which exceed the cost of a normal diet.

"Formula" is an enteral product for use at home that is prescribed by a Physician.

"Special food product" is a food product that is prescribed by a Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

- Your Primary Care Physician or a referral Physician gives a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of treatment you have received;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including but not limited to a Serious Chronic Condition; or
- Your Primary Care Physician or a referral Physician is unable to diagnose your condition, or test results are conflicting.

To request an authorization for a second opinion, contact your Primary Care Physician or the Customer Contact Center at the telephone number on your Health Net ID card. Physicians at your Physician Group or Health Net will

review your request in accordance with Health Net's procedures and timelines as stated in the second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments. You may obtain a copy of this policy from the Customer Contact Center.

All authorized second opinions must be provided by a Physician who has training and expertise in the illness, disease or condition associated with the request.

Mental Health and Substance Abuse Services

University of California has independently contracted with Optum , a specialized health care service plan, to provide Mental Health and Substance Abuse Services. Covered Services may be obtained by receiving a referral through Optum at **1-888-440-UCAL (8225)**. Care must be provided by an Optum participating provider and approved by Optum. Special provisions apply in the event of an emergency, and are described in detail in the Optum Evidence of Coverage (EOC).

Additional Benefits are provided for those Members having a diagnosis categorized as Severe Mental Illness. Please contact Optum at **1-888-440-UCAL (8225)** for a complete schedule of your Mental Health and Substance Abuse Services.

Prescription Drugs

Please read the "Prescription Drugs" portion of "Exclusions and Limitations," Section 6.

Covered Drugs and Supplies

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "Exclusion and Limitations" Section 6, to find out if a particular condition is not covered.

Tier 1 Drugs (Primarily Generic) and Tier 2 Drugs (Primarily Brand)

Tier 1 and Tier 2 Drugs listed in the Health Net Commercial Formulary (also referred to as "the List") are covered, when dispensed by Participating Pharmacies and prescribed by a Physician from your selected Physician Group, an authorized referral Specialist or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net in order to be covered. The fact that a drug is listed in the Commercial Formulary does not guarantee that your Physician will prescribe it for you for a particular medical condition.

Tier 3 Drugs

Level III Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Tier 3 on the Commercial Formulary; or
- Not listed in the Health Net Commercial Formulary and are not excluded or limited from coverage.

Some Tier 3 Drugs require Prior Authorization from Health Net in order to be covered.

Please refer to the "Commercial Formulary" portion of this section for more details.

Generic Equivalents to Brand Name Drugs

Generic Drugs will be dispensed when a Generic Drug equivalent is available, unless a Brand Name Drug is specifically requested by the Physician or the Member, subject to the Copayment requirements described in the "Prescription Drugs" portion of "Schedule of Benefits and Copayments," Section 2.

Off-Label Drugs

A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

- The drug is approved by the Food and Drug Administration AND
- The drug meets one of the following conditions:
    1. The drug is prescribed by a participating licensed health care professional for the treatment of: a life-threatening condition; OR

2. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Commercial Formulary or Prior Authorization by Health Net has been obtained; AND

- The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:

A. The American Hospital Formulary Service Drug Information; OR

B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:

i. The Elsevier Gold Standard's Clinical Pharmacology.

ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.

iii. The Thomson Micromedex DrugDex; OR

C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening," means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Commercial Formulary. Diabetic supplies are also covered including but not limited to specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to "Medical Services and Supplies" portion of this Section under "Diabetic Equipment, "for additional information. Refer to "Schedule of Benefits and Copayments," Section 3, for details about the supply amounts that are covered and the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Commercial Formulary. Inhaler spacers and peak flow meters used for the management and treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section under "Durable Medical Equipment" for additional information.

Smoking Cessation Coverage

Drugs for the relief of nicotine withdrawal symptoms require a prescription from the treating Physician. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com/uc.

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. These Prescription Drugs are covered for up to the number of doses or tablets specified in Health Net's Commercial Formulary. For information about Health Net's Commercial Formulary, please call the Customer Contact Center at the telephone number on your ID card. Drugs (including injectable medications) prescribed for treatment of sexual dysfunction are not available through mail order or under the 90-day Maintenance Drug Benefit

Specialty Drugs

Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and usually require close monitoring. These drugs may have limited pharmacy availability or distribution and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously). Specialty Drugs are identified in the Health Net Commercial Formulary with "SP". Refer to Health Net's Commercial Formulary on our website at healthnet.com for the Specialty Drugs listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

All Specialty Drugs require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Specialty Drugs are not available through mail order.

Self-injectable drugs (other than insulin), including drugs for the treatment of hemophilia, and needles and syringes used with these self-injectable drugs are included under Specialty Drugs, which are subject to Prior Authorization and must be obtained through Health Net's contracted specialty pharmacy vendor. Your PCP or treating Physician will coordinate the authorization and upon approval the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor may contact you directly to coordinate the delivery of your medications.

Preventive Drugs and Women's Contraceptives:

Preventive drugs, including smoking cessation drugs, and women's contraceptives are covered at no cost to the Member. Covered preventive drugs are over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.

Drugs for the relief of nicotine withdrawal symptoms require a prescription from the treating Physician. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com/uc.

Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a Prescription Drug Order. Women's contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal and emergency contraceptives. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Commercial Formulary.

Over-the-counter preventive drugs and women's contraceptives that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs or contraceptives.

Intrauterine devices (IUDs), injectable and implantable contraceptives are covered as a medical benefit when administered by a Physician. Please refer to the "Medical Services and Supplies" portion of this section, under the headings "Preventive Care Services" and "Family Planning" for information regarding contraceptives covered under the medical benefit.

For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy. Emergency contraceptives required in conjunction with Emergency Care, as defined under "Definitions", Section 9, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Care as defined

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs that require a prescription in order to be dispensed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity. The prescribing Physician must request and obtain Prior Authorization for coverage.

The Commercial Formulary

What Is the Health Net Commercial Formulary?

Health Net developed the Commercial Formulary to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Health Net contracting Physicians and Specialists that they refer to this List when choosing drugs for patients who are Health Net Members. When your Physician prescribes medications listed in the Commercial Formulary, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Commercial Formulary identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

You may call the Customer Contact Center at the telephone number on your Health Net ID Card to find out if a particular drug is listed in the Commercial Formulary. You may also request a copy of the current List, and it will be mailed to you. The current List is also available on the Health Net website at www.healthnet.com/uc.

How Are Drugs Chosen for the Health Net Commercial Formulary?

The List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the List, the Committee reviews medical and scientific publications, relevant utilization experience and Physician recommendations to assess the drug for its:

- Safety
- Effectiveness
- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed)
- Side effect profile
- Therapeutic outcome

This Committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the List. The Commercial Formulary is updated as new clinical information and medications are approved by the FDA.

Who Is on the Health Net Pharmacy and Therapeutic Committee and How Are Decisions Made?

The Committee is made up of actively practicing Physicians of various medical specialties from Health Net Physician Groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Commercial Formulary. The voting members are not employees of Health Net. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process for Prescription Drugs

Prior Authorization status is included in the Commercial Formulary – The Commercial Formulary identifies which drugs require Prior Authorization. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net. You may obtain a list of drugs requiring Prior Authorization by visiting our website at www.healthnet/uc.com or call the Customer Contact Center at the telephone number on your Health Net ID card. If a drug is not on the Commercial Formulary, your Physician should call Health Net to determine if the drug requires Prior Authorization.

Health Net may approve a drug not on the Commercial Formulary if Medical Necessity is demonstrated by the prescribing Physician as follows:

- Drugs on the Commercial Formulary have already been tried and were not effective;
- The medication being considered meets Health Net's usage guidelines; and
- The medication is not excluded from the Member's Plan.

Your Physician should call Health Net to request Prior Authorization for drugs not on the Commercial Formulary.

Requests for Prior Authorization may be submitted by telephone or facsimile. Urgent requests from Physicians for authorization are processed as soon as possible, not to exceed 24 hours after Health Net's receipt of the request

and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the Health Net Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact Health Net to obtain the usage guidelines for specific medications.

Once a medication is approved, its authorization becomes effective immediately.

If you are denied Prior Authorization, please refer to the "Grievance, Appeals, Independent Medical Review and Arbitration" portion of the "General Provisions" section of this *Evidence of Coverage*.

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

Except as described below under "Nonparticipating Pharmacies and Emergencies" and "Drugs Only Dispensed by Mail Order", you must purchase covered drugs at a Participating Pharmacy.

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy please visit our website at www.healthnet.com/uc or call the Customer Contact Center at the telephone number on your Health Net ID card. Present the Health Net ID Card and pay the appropriate Copayment when the drug is dispensed.

Up to a 30-consecutive-calendar-day supply is covered for each Prescription Drug Order. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard units. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. If the Health Net ID Card is not available or eligibility cannot be determined:

- Pay the entire cost of the drug; and
- Submit a claim for possible reimbursement.

Health Net will reimburse you for the cost of the Prescription Drug, less any required Copayment shown in the "Schedule of Benefits and Copayments," Section 3.

Except as described below in "Nonparticipating Pharmacies and Emergencies," for new Members and emergent care, if you elect to pay out-of-pocket and submit a prescription claim directly to Health Net instead of having the contracted pharmacy submit the claim directly to Health Net, you will be reimbursed based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price, less any applicable Copayment or Deductible.

You may obtain maintenance drugs on the Health Net Maintenance Drug List up to a 90-consecutive calendar day supply from a CVS retail pharmacy, a UC walk-up pharmacy or through Mail Order and pay your mail order copayment.

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID Card. After 30 days, Prescription Drugs dispensed by a Non-Participating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in "Definitions," Section 9.

If the above situations apply to you:

- Pay the full cost of the Prescription Drug that is dispensed; and

- Submit a claim to Health Net for possible reimbursement.

Health Net will reimburse you Prescription Drug covered expenses, less any required Copayment shown in "Schedule of Benefits and Copayments," Section 3.

If you present a Prescription Order for a Brand Name Drug, the pharmacist will offer a Generic Drug equivalent if commercially available. In cases of Emergency or Urgently Needed Care, you should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

There are no benefits through Nonparticipating Pharmacies after 30 days of coverage or if the Prescription Drug was not purchased for Emergency or Urgently Needed Care.

Note: The "Prescription Drug" portion of "Exclusions and Limitations," Section 6, of this *Evidence of Coverage* and the requirements of the Commercial Formulary described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at www.healthnet.com/uc.

Drugs Dispensed by Mail Order or Walk-up Service

If your prescription is for a Maintenance Drug and your doctor has written a prescription for a 90-days supply, you may have the option of filling it through our convenient mail order program, at a CVS Retail Pharmacy, or at a UC Walk-up pharmacy. Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

You may call the Customer Contact Center at the telephone number on your Health Net ID Card to find out if a particular drug is a Maintenance Drug that is listed on the Health Net Maintenance Drug List. You may also request a copy of Health Net's Maintenance Drug List (MDL) and it will be mailed to you. The MDL is also available on the Health Net website at www.healthnet.com/uc.

To receive Prescription Drugs by mail send the following to the designated mail order administrator:

- The completed Prescription Mail Order Form;
- The original Prescription Drug Order (not a copy) written for up to a 90-consecutive-calendar-day-supply of a Maintenance Drug, when appropriate; and
- The appropriate Copayment.

You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at the telephone number on your Health Net ID Card.

The mail order administrator may dispense up to a 90-consecutive-calendar-day supply of a covered Maintenance Drug and each refill allowed by that order. The required Copayment applies each time a drug is dispensed. In some cases, a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the mail order may be less than a 90-consecutive-calendar-day supply.

UC members can also obtain their mail order prescriptions at a designated UC Medical Center pharmacy. To locate a UC Medical Center pharmacy, a listing is provided on the HR/Benefits website or contact Health Net customer service.

Schedule II Narcotic Drugs

Specialty Drugs and Schedule II narcotic drugs are not covered through our mail order or under the 90-day Maintenance Drug Benefit program. Refer to the "Prescription Drug" portion of the "Exclusions and Limitations" section for more information.

Chiropractic Services and Supplies

Please read "Chiropractic Services and Supplies" portion of "Exclusions and Limitations," Section 6.

Chiropractic Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 2.

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any Contracted Chiropractor without a referral from a Physician or your Primary Care Physician.

You may receive covered Chiropractic Services from any Contracted Chiropractor at any time and you are not required to pre-designate the Contracted Chiropractor prior to your visit from whom you will receive covered Chiropractic Services. You must receive covered Chiropractic Services from a Contracted Chiropractor, except that:

- You may receive Emergency Chiropractic Services from any chiropractor, including a non-Contracted Chiropractor; and
- If covered Chiropractic Services are not available and accessible to you in the county in which you live, you may obtain covered Chiropractic Services from a non-Contracted Chiropractor who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered Chiropractic Services require pre-approval by ASH Plans except:

- A new patient examination by a Contracted Chiropractor and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic Services including, without limitation, any referral for x-ray services, radiological consultations, or laboratory services.

The following benefits are provided for Chiropractic Services:

Office Visits

- A new patient exam or an established patient exam is performed by a Contracted Chiropractor for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

  Established patient exams are performed by a Contracted Chiropractor to assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of Chiropractic Services. The established patient exam must be Medically Necessary.

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.

- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Second Opinion

If you would like a second opinion with regard to covered services provided by a Contracted Chiropractor, you will have direct access to any other Contracted Chiropractor. Your visit to a Contracted Chiropractor for purposes of obtaining a second opinion will count as one visit, for purposes of any maximum benefit and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Contracted Chiropractor.

However, a visit to a second Contracted Chiropractor to obtain a second opinion will not count as a visit, for purposes of any maximum benefit, if you were referred to the second Contracted Chiropractor by another Contracted Chiropractor (the first Contracted Chiropractor). The visit to the first Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests

X-rays and laboratory tests are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as Medically Necessary Chiropractic Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH Plans to provide those services. A Copayment is not required.

X-ray second opinions are covered only when performed by a radiologist to verify suspected tumors or fractures.

Chiropractic Appliances

Chiropractic Appliances are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans for up to the maximum benefit shown in "Schedule of Benefits and Copayments," Section 2.

Acupuncture Services

Please read "Acupuncture Services" portion of "Exclusions and Limitations," Section 6.

Acupuncture Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 2.

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Acupuncture Services for you. You may access any Contracted Acupuncturist without a referral from a Physician or your Primary Care Physician.

You may receive covered Acupuncture Services from any Contracted Acupuncturist, and you are not required to pre-designate a Contracted Acupuncturist prior to your visit from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from a Contracted Acupuncturist except that:

- You may receive Emergency Acupuncture Services from any acupuncturist, including a non-Contracted Acupuncturist; and
- If covered Acupuncture Services are not available and accessible to you in the county in which you live, you may obtain covered Acupuncture Services from a non-Contracted Acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered Acupuncture Services require pre-approval by ASH Plans except:

- A new patient examination by a Contracted Acupuncturist and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Acupuncture Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Acupuncture Services.

The following benefits are provided for Acupuncture Services:

Office Visits

- A new patient exam or an established patient exam is performed by a Contracted Acupuncturist for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Acupuncture Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

  Established patient exams are performed by a Contracted Acupuncturist to assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam must be Medically Necessary.

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.

- Adjunctive therapy may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.

- Only the treatment of Pain, Nausea or Neuromusculoskeletal Disorders is covered, provided that the condition may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice. Covered Pain includes low back Pain, post-operative Pain and post-operative dental Pain. Nausea includes adult post-operative Nausea and vomiting, chemotherapy Nausea and vomiting and Nausea of pregnancy. Neuromusculoskeletal Disorders include musculoskeletal conditions such as fibromyalgia and myofascial Pain. Other conditions for which covered services also are available, if Medically Necessary, include carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow.

Second Opinion

If you would like a second opinion with regard to covered services provided by a Contracted Acupuncturist, you will have direct access to any other Contracted Acupuncturist. Your visit to a Contracted Acupuncturist for purposes of obtaining a second opinion will count as one visit, for purposes of any maximum benefit and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Contracted Acupuncturist. However, a visit to a second Contracted Acupuncturist to obtain a second opinion will not count as a visit, for purposes of any maximum benefit, if you were referred to the second Contracted Acupuncturist by another Contracted Acupuncturist (the first Contracted Acupuncturist). The visit to the first Contracted Acupuncturist will count toward any maximum benefit.

6. EXCLUSIONS AND LIMITATIONS

It is extremely important to read this section before you obtain services in order to know what Health Net will and will not cover.

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the *Evidence of Coverage* exceed *Evidence of Coverage* limitations or are Follow-Up Care (or related to Follow-Up Care) to *Evidence of Coverage* exclusions or limitations will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic Health Care Service under applicable law, or is required to be covered by other state or federal law, and is Medically Necessary as defined in "Definitions," Section 9. Notwithstanding any exclusions or limitations described in this Evidence of Coverage, all Medically Necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.

General Exclusions and Limitations

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this *Evidence of Coverage.*

Ambulance Services

Air and ground ambulance and ambulance transport services are covered as shown in the "Ambulance Services" provision of "Covered Services and Supplies," Section 5.

Paramedic, ambulance, or ambulance transport services are not covered in the following situations:

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Care were not met, unless authorized by your Physician Group, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies," Section 5; or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this *Evidence of Coverage*; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care

This Plan does not cover services and supplies that are provided primarily to assist with the activities of daily living, regardless of where performed.

Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant or physical, speech or occupational therapist or other licensed health care provider.

Please see the "Hospice Care" provisions in the "Covered Services and Supplies" and "Definitions" sections for services that are provided as part of that care, when authorized by the Plan or the Member's contracted Physician Group. .

Disposable Supplies for Home Use
This Plan does not cover disposable supplies for home use.

Experimental or Investigational Services
Experimental or Investigational drugs, devices, procedures or other therapies are only covered except when:

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of "General Provisions," Section 7 for more information; or
- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Clinical Trials" provision in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Home Birth
A birth which takes place at home will be covered only when the criteria for Emergency Care, as defined in this *Evidence of Coverage*, have been met.

Ineligible Status
This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered, except as specified in the "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 1.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

No-Charge Items
This Plan does not cover reimbursement to the Member for services or supplies for which the Member is not legally required to pay the provider or for which the provider pays no charge.

Personal or Comfort Items
This Plan does not cover personal or comfort items.

Unlisted Services
This Plan only covers services or supplies that are specified as covered services or supplies in this Evidence of Coverage, unless coverage is required by state or federal law.

Services and Supplies
In addition to the exclusions and limitations shown in the "General Exclusions and Limitations" portion of this section, the following exclusions and limitations apply to services and supplies under the medical benefits and the Mental Disorders and Chemical Dependency benefits:

Aversion Therapy
Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

Biofeedback
Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders such as incontinence and chronic Pain, and as otherwise preauthorized by the Plan.

Blood
Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. Self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group or Health Net has authorized and scheduled.

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or

Investigational in nature. See "General Provisions," Section 7, for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Conception by Medical Procedures

Artificial insemination and gamete intrafallopian transfer (GIFT) are covered when a Member and/or the Member's partner is infertile (refer to Infertility in "Definitions" Section 9), but the services will only be covered for a Member. The collection, storage or purchase of sperm is not covered.

Other services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting, or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.
- Injections for Infertility when not provided in connection with services that are covered by this Plan.

Cosmetic Services and Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Member are not covered. However, the Plan does cover Medically Necessary services and supplies for complications, which exceed routine Follow-Up Care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair analysis, hairpieces and wigs, cranial/hair prostheses chemical face peels, abrasive procedures of the skin or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and such surgery does either of the following:

- Improve function:
- Create a normal appearance to the extent possible,

Then, the following are covered

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to remove or reduce skin or tissue, or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

In addition, when a Medically Necessary mastectomy (including lumpectomy) has been performed, the following are covered:

- Breast reconstruction surgery; and
- Surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breasts.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

*The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the **Women's Health and Cancer Rights Act of 1998.***

Dental Services

Dental services or supplies are limited to the following situations:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of Section 2, "Introduction to Health Net," for more information.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary are subject to the other exclusions and limitations of this *Evidence of Coverage*, and will only be covered under the following circumstances (a) Members who are under seven years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

The following services are not covered under any circumstances except as described above for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or Orthotics (whether custom fit or not) or other dental appliances, and related surgeries to treat dental conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD/TMJ disorders are covered if they are Medically Necessary, as described in the "Disorders of the Jaw" provision of this section.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 5).

Disorders of the Jaw

Treatment for disorders of the jaw is limited to the following situations:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices; orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants or other dental appliances, and related surgeries to treat dental conditions are not covered under any circumstances.
- Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics inlays, or onlays, crowns, bridgework, dental splints, dental implants or other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered, as stated in the "Dental Services" provision of this section.

TMD is generally caused when the chewing muscles and jaw joint do not work together correctly, and may cause headaches, tenderness in the jaw muscles, tinnitus or facial Pain.

Durable Medical Equipment

Although this Plan covers Durable Medical Equipment, it does not cover the following items:

- Exercise equipment
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services)
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools
- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the "Prostheses" provision of "Covered Services and Supplies," Section 5. and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of "Covered Services and Supplies," Section 5.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this Plan.

Eyeglasses and Contact Lenses

This Plan does not cover Eyeglasses or Contact Lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Fertility Preservation

Fertility preservation treatments are covered as shown in the "Family Planning" provision in "Covered Services and Supplies," Section 5. However, the following services and supplies are not covered:

- Gamete or embryo storage
- Use of frozen gametes or embryos to achieve future conception
- Pre-implantation genetic diagnosis
- Donor eggs, sperm or embryos
- Gestational carriers (surrogates)

Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Member has no medical indication or family history of a genetic abnormality.

Mental Health and Substance Abuse Benefits

University of California has independently contracted with Optum , a specialized health care service plan, to provide Mental Health and Substance Abuse services. Services, treatments and supplies that are not Covered Services under the Optum Plan are described in detail in the Optum Evidence of Coverage (EOC).

Methadone Treatment

Methadone maintenance for the purpose of long term opiate craving reduction is not covered.

Noneligible Institutions

This Plan only covers Medically Necessary services or supplies provided by a licensed Hospital, Medicare-approved Skilled Nursing Facility, Residential Treatment Center or other properly licensed medical facility

specified as covered in this Evidence of Coverage. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription drug order is not covered even if a Physician writes a Prescription drug order for such drug, equipment or supply unless listed in the Commercial Formulary. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

Nonstandard Therapies

Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered.

For information regarding requesting an Independent Medical Review of a denial of coverage see the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions," Section 7.

Physician Self-Treatment

This Plan does not cover Physician self-treatment rendered in a non-emergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in the "Prescription Drug Benefits" portion of "Covered Services and Supplies," Section 5.

Private Duty Nursing

This Plan does not cover Private Duty Nursing in the home or for registered bed patients in a Hospital or long-term care facility. Shift care and any portion of shift care services are also not covered.

Psychological Testing

Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.

Refractive Eye Surgery

This Plan does not cover eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), or astigmatism, unless Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net.

Rehabilitation Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contracted Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license subject to any required authorization from the Plan or the Member's Physician Group. The services must be based on a treatment plan authorized, as required by the Plan or the Member's Physician Group. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See "General Provisions" Section 7, for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Residential Treatment Center

Admission to a Residential Treatment Center that is not Medically Necessary is excluded. Admissions that are not considered Medically Necessary and are not covered include, but are not limited to admissions for Custodial Care, for a situational or environmental change only; or as an alternative to placement in a foster home or halfway house.

Routine Foot Care
This Plan does not cover services for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.

Reversal of Surgical Sterilization
This Plan does not cover services to reverse voluntary, surgically induced sterility.

Routine Physical Examinations
This Plan does not cover routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization. See "Health Evaluations Preventive Care Services" in "Covered Services and Supplies" Section 5, for information about coverage of examinations that are for preventive health purposes.

Services for Educational or Training Purposes
Except for services related to behavioral health treatment for pervasive development disorder or autism are covered as shown in "Covered Services and Supplies," Section 5, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California. Examples of excluded services include education and training for non-medical purposes such as:

- Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. For example: The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching members how to read; educational testing or academic education during residential treatment.
- Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
- Teaching manners or etiquette appropriate to social activities.
- Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for behavioral health treatment as indicated above in conjunction with the diagnosis of pervasive development disorder or autism.

Services Not Related To Covered Condition, Illness Or Injury
Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services or supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Sports Activities
Sports activities, including, but not limited to, yoga, rock climbing, hiking and swimming, are not covered.

State Hospital Treatment
Services in a state Hospital are limited to treatment or confinement as the result of an Emergency or Urgently Needed Care as defined in "Definitions," Section 9.

Surrogate Pregnancy
This Plan covers services for a surrogate pregnancy when the surrogate is a Health Net Member. When compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision are subject to the Plan's right to recovery as described in "Recovery of Benefits Paid by Health Net Under A Surrogate Parenting Agreement" in the "Specific Provisions" section of this *Evidence of Coverage*.

Treatment by Immediate Family Members
This Plan does not cover routine or ongoing treatment, consultation or provider referrals (including, but not limited to, prescribed services, supplies and drugs) provided by the Member's parent, spouse, Domestic Partner, child,

stepchild or sibling. Members who receive routine or ongoing care from a member of their immediate family will be reassigned to another Physician at the contracting Physician Group (medical).

Treatment of Obesity
Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity. Certain services may be covered as Preventive Care Services; refer to the "Preventive Care Services" provision in "Covered Services and Supplies," Section 5.

Treatment Related to Judicial or Administrative Proceedings
Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered testing are limited to Medically Necessary covered services.

Unauthorized Services and Supplies
This Plan only covers services or supplies that are authorized by Health Net or the Physician Group according to Health Net's procedures, except for emergency services.

Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by your Physician Group (medical) or when you require Emergency or Urgently Needed Care.

Vision Therapy, Eyeglasses and Contact Lenses
This Plan does not cover vision therapy, Eyeglasses or Contact Lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Prescription Drugs
The exclusions and limitations in the "General Exclusions and Limitations " and "Services and Supplies" portions of this section also apply to the coverage of Prescription Drugs.

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5, for more information.

Additional exclusions and limitations:

Allergy Serum
Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See the "Allergy, Immunizations and Injections" portion of the "Schedule of Benefits and Copayments" Section 3 and the "Immunizations and Injections" portion of "Covered Services and Supplies" section.

Appetite Suppressants or Drugs for Body Weight Reduction
Drugs prescribed for the treatment of obesity are covered, when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to Prior Authorization from Health Net.

Compounded Drugs
Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered. Coverage for Compounded Drugs is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," section 5, for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier 3 Drug Copayment and is subject to Prior Authorization by the Plan and Medical Necessity.

Devices
Coverage is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and those devices listed under the "Diabetic Drugs and Supplies" provisions of the "Prescription Drugs" portion of "Covered Services and Supplies" Section 5. No other devices are covered even if prescribed by a Member Physician.

Diagnostic Drugs
Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Dietary or Nutritional Supplements
Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product are limited to drugs that are listed in the Commercial Formulary. Phenylketonuria (PKU) treatment is covered under the medical benefit (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 5.

Drugs Prescribed for the Common Cold
Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed by a Dentist
Drugs prescribed for routine dental treatment are not covered.

Drugs Prescribed for Cosmetic or Enhancement Purposes
Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, latisse, Renova, Retin-A, Vaniqua, Propecia, or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia.

Food and Drug Administration (FDA)
Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except as described under the "Clinical Trials" provision in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, and the "Experimental or Investigational Services" provision of this "Exclusions and Limitations" section.

Hypodermic Syringes and Needles
Hypodermic syringes and needles are limited to disposable insulin needles and syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net's specialty pharmacy vendor under the Medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies," Section 5). All other syringes, devices and needles are not covered.

Self-Injectable Drugs
Self-injectable drugs obtained through a prescription are limited to insulin and sexual dysfunction drugs when prescribed by a Physician. Other self-injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies" Section 5). Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of "Covered Services and Supplies," Section 5.

Irrigation Solutions
Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs
Drugs that are not approved by the FDA are not covered. lost, stolen or damaged are not covered. You will have to pay the retail price for replacing them.

Nonapproved Uses
Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the "Off-Label Drugs" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 5)

Noncovered Services
Drugs prescribed for a condition or treatment that is not covered by this Plan are not covered. However, the Plan does cover Medically Necessary drugs for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Nonparticipating Pharmacies
Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "Nonparticipating Pharmacy and Emergencies" provision of "Covered Services and Supplies," Section 5.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies
Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless it is listed in the Commercial Formulary. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered when Medically Necessary.

Physician Is Not a Member Physician
Drugs prescribed by a Physician who is not a Member Physician or an authorized Specialist are not covered, except when the Physician's services have been authorized because of a medical Emergency condition, illness, or injury, or as specifically stated.

Unit Dose or "Bubble" Packaging
Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Quantity Limitation
Some drugs are subject to specific quantity limitations per Copayment based on recommendations for use by the FDA or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

Chiropractic Services and Supplies

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section apply to Chiropractic Services.

Note: Services or supplies excluded under the chiropractic benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5, for more information.

Services, laboratory tests and x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Anesthesia
Charges for anesthesia are not covered.

Diagnostic Radiology
Coverage is limited to X-rays. No other diagnostic radiology (including magnetic resonance imaging or MRI) is covered.

Drugs
Prescription drugs and over-the-counter drugs are not covered.

Durable Medical Equipment
Durable Medical Equipment is not covered.

Educational Programs
Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Chiropractic Services
Chiropractic care that is (a) investigatory; or (b) an unproven chiropractic service that does not meet generally accepted and professionally recognized standards of practice in the chiropractic provider community is not covered. ASH Plans will determine what will be considered Experimental or Investigational.

Hospital Charges
Charges for Hospital confinement and related services are not covered.

Hypnotherapy
Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.

Non-Contracted Providers
Services or treatment rendered by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a referral by ASH Plans.

Nonchiropractic Examinations
Examinations or treatments for conditions unrelated to neuromusculoskeletal Disorders are not covered. This means that physical therapy not associated with spinal, muscle and joint manipulation, is not covered.

Out-of-State Services
Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.

Services Not Within License
Services that are not within the scope of license of a licensed chiropractor in California.

Thermography
The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs
Transportation costs are not covered, including local ambulance charges.

Medically/Clinically Unnecessary Services
Only Chiropractic Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Vitamins
Vitamins, minerals, nutritional supplements or other similar products, including when in combination with a prescription product, are not covered.

Acupuncture Services

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section also apply to Acupuncture Services.

Note: Services or supplies excluded under the acupuncture benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 5, for more information.

Services, laboratory tests, x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that

the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at 1-800-678-9133 for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Auxiliary Aids
Auxiliary aids and services are not covered. This includes but is not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

Diagnostic Radiology
Coverage is limited to X-rays if approved by ASH Plans and documented as Medically/Clinically Necessary. No other diagnostic radiology (including magnetic resonance imaging or MRI) is covered.

Drugs
Prescription drugs and over-the-counter drugs are not covered.

Durable Medical Equipment
Durable Medical Equipment is not covered.

Educational Programs
Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Acupuncture Services
Acupuncture care that is (a) investigatory; or (b) an unproven Acupuncture Service that does not meet generally accepted and professionally recognized standards of practice in the acupuncture provider community is not covered. ASH Plans will determine what will be considered Experimental or Investigational.

Hospital Charges
Charges for Hospital confinement and related services are not covered.

Anesthesia
Charges for anesthesia are not covered.

Hypnotherapy
Hypnotherapy, sleep therapy, behavior training and weight programs are not covered.

Non-Contracted Providers
Services or treatment rendered by acupuncturists who do not contract with ASH Plans are not covered, except with regard to Emergency Acupuncture Services or upon referral by ASH Plans.

Acupuncture Services Not Listed under Acupuncture Services
Only Acupuncture Services that are listed under "Acupuncture Services" are covered. Unlisted services, which include, without limitation, services to treat asthma and services to treat any addiction, including treatment for smoking cessation, are not covered.

Out-of-State Services
Services provided by an acupuncturist practicing outside California are not covered, except with regard to Emergency Acupuncture Services.

Thermography
The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs
Transportation costs are not covered, including local ambulance charges.

Medically/Clinically Unnecessary Services
Only Acupuncture Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Services Not Within License
Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also sometimes called "ear candling," involves the insertion of one end of a long, flammable cone ("ear cone") into the ear canal. The

other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

Vitamins

Vitamins, minerals, nutritional supplements or other similar products are not covered.

7. GENERAL PROVISIONS

When the Plan Ends

The UC Standardized Contract specifies how long this Plan remains in effect.

If you are totally disabled on the date that the UC Standardized Contract is terminated, benefits will continue according to the "Extension of Benefits" portion of "Eligibility, Enrollment, and Termination, " Section 1.

When the Plan Changes

Subject to notification and according to the terms of the UC Standardized Contract, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions, and eligibility provisions.

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the UC Standardized Contract. Notice of modification will be sent to the Group. Except as required under "Eligibility, Enrollment and Termination" Section 1, Subsection D, "When Coverage Ends" regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.

If you are confined in a Hospital when the UC Standardized Contract is modified, benefits will continue as if the Plan had not been modified, until you are discharged from the Hospital.

Form or Content of the Plan: No agent or employee of Health Net is authorized to change the form or content of this Plan. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.

Customer Contact Center Interpreter Services

Health Net's Customer Contact Center has bilingual staff and interpreter services for additional languages to handle Member language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to your health plan in your preferred language. Also, our Customer Contact Center staff can help you find a health care provider who speaks your language. Call the Customer Contact Center number on your Health Net ID card for this free service. Health Net discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available at no charge.

Members' Rights and Responsibilities Statement

Health Net is committed to treating Members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted these Members' rights and responsibilities. These rights and responsibilities apply to Members' relationships with Health Net, its contracting practitioners and providers, and all other health care professionals providing care to its Members.

Members have the right to:

- Receive information about Health Net, its services, its practitioners and providers and Members' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to you;

- Use interpreters who are not your family members or friends;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com/uc;
- File a complaint if your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon on with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

Appeal, complaint or grievance means any dissatisfaction expressed by you or your representative concerning a problem with Health Net, a medical provider or your coverage under this EOC, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-800-539-4072** or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com/uc. You may also file your complaint in writing by sending information to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the Mental Health and Substance Abuse, please call OPTUM) at 1-888-440-8225.

You may write to:

OPTUM
Appeals & Grievances
P.O Box 32040
Oakland, CA 94604

If your concern involves the chiropractic program, call the Health Net Customer Contact Center at **1-800-539-4072** or write to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the acupuncture program, call the Health Net Customer Contact Center at **1-800-539-4072** or write to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

You must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. Please include all information from your Health Net Identification Card and the details of the concern or problem.

We will:

- Confirm in writing within five calendar days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the Department of Managed Health Care for assistance or to request an independent medical review or you may initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (Department) if you believe that health care services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any Health Care Service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR, which are set out below:

1. (A) Your provider has recommended a Health Care Service as Medically Necessary; or

   (B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary;

   (C) In the absence of the provider recommendation described in 1. (A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified, or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the Health Care Service is not Medically Necessary; and

3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process, or to request an application form, please call the Customer Contact Center at **1-(800)-539-4072** the telephone number on your Health Net ID card.

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review ("IMR") of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.
2. Your Physician must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate, and there is no more beneficial therapy covered by Health Net.
3. Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or as an alternative, you submit a request for a therapy that, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
4. You have been denied coverage by Health Net for the recommended or requested therapy.
5. If not for Health Net's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at **1-800-539-4072** the telephone number on your Health Net ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan.)

If you have a grievance against Health Net, you should first telephone Health Net at 1-800-539-4072 and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, then you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department's also has a toll-free telephone number (**1-888-HMO-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired.

The Department' s Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise and whether or not other parties such as employer groups, health care providers or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician, or the contracting Physician Group.

  Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.

- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.

- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.

- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S. the treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org). Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

Health Net will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New

technologies are considered Investigational or Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational or Experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or Investigational or Experimental, following extensive review of medical research by appropriately specialized Physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or Investigational or Experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

Health Net and the health care providers that provide services to you through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover for the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions responsible party are:

- You are in a car accident; or
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, Health Net's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this plan, you also grant Health Net an assignment of your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such medical payments carriers to directly reimburse the Plan on your behalf.

STEPS YOU MUST TAKE

If you are injured because of a responsible party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties any insurance companies; or any other sources;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan; and
- Hold any money that you or your lawyer receive from the responsible parties or from any other sources, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, Hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a prorated share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.

** Reimbursement related to Workers' Compensation benefits, ERISA plans, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Certificate and applicable law.*

Surrogacy Arrangements

A Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to Health Net

If you enter into a surrogacy arrangement, you must pay us for covered services and supplies you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments you and/or any of your family members are entitled to receive under the surrogacy arrangement. You also agree to pay us for the covered services and supplies that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if you provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to Health Net in advance of delivery, you will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Duty to Cooperate

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

Surrogacy Third Party Liability –Product Support
The Rawlings Company
One Eden Parkway
LaGrange, KY 40031-8100

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to your surrogacy arrangement and to satisfy Health Net's rights.

You must do nothing to prejudice the health plan's recovery rights.

You must also provide us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals, and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital, or other health care provider.

All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of this Plan.

The Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees, or of Physician Groups, any Physician or Hospital, or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of this Plan.

Provider/Patient Relationship

Member Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges

While it is not likely, it is possible that Health Net may be unable to pay a Health Net provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with Health Net. You may be held liable for the cost of services or supplies received from a noncontracting provider if Health Net does not pay that provider.

This provision does not affect your obligation to pay any required Copayment or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability

Health Net will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing, or use of any Prescription Drug this Plan covers.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other Hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the Effective Date of the contract termination.

In addition, a Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 9, of this *Evidence of Coverage*.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information on how to request continued care or request a copy of the Continuity of Care Assistance Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID Card.

Contracting Administrators

Health Net may designate or replace any contracting administrator that provides the covered services and supplies of this Plan. If Health Net designates or replaces any administrator and as a result procedures change, Health Net will inform you.

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this *Evidence of Coverage*.

Decision-Making Authority

Health Net has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Coordination of Benefits

The Member's coverage is subject to the same limitations, exclusions and other terms of this Evidence of Coverage whether Health Net is the Primary Plan or the Secondary Plan.

Coordination of benefits (COB) is a process, regulated by law, that determines financial responsibility for payment of allowable expenses between two or more group health Plans.

Allowable expenses are generally the cost or value of medical services that are covered by two or more group health plans, including two Health Net plans.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health plan provides benefits in the form of services rather than cash payments.

Health Net's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between the two HMOs or insurers. However, you may occasionally be asked to provide information about your other coverage.

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions apply to the coverage provided under this Subsection only.

A. **Plan**--A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   (1) **"Plan" includes** group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

   (Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits please refer to "Government Coverage" portion of this "General Provisions," Section 7.)

   (2) **"Plan" does not include** nongroup coverage of any type, amounts of hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

   Each contract for coverage under (1) and (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan**--The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits.

C. **Allowable Expense**--This concept means a Health Care Service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

The following are examples of expenses or services that are **not Allowable Expense:**

(1) If a covered person is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

Exception:

If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

(5) The amount a benefit is reduced by the Primary Plan because of a covered person does not comply with the plan provisions is not an Allowable Expense.

Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

D. **Claim Determination Period**--This is the Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

E. **Closed Panel Plan**--This is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**--This is a parent who has been awarded custody of a child by a court decree. In the absence of a court decree, it is the parent with whom the child resided more than half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among Health Net and other applicable group health Plans by establishing which Plan is primary, secondary and so on.

A. **Primary or Secondary Plan**--The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. **No COB Provision**--A Plan that does not contain a coordination of benefits provision is always primary.

There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a closed Panel Plan to provide out-of-network benefits.

C. **Secondary Plan Performs COB**--A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. **Order of Payment Rules**--The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) vs. Dependent**--The Plan that covers the person other than as a dependent, for example as an employee, Subscriber, or retiree, is primary, and the Plan that covers the person as a dependent is secondary.
2. **Child Covered By More Than One Plan**--The order of payment when a child is covered by more than one Plan is:
   a. **Birthday Rule**--The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. **Court Ordered Responsible Parent**--If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
   c. **Parents Not Married, Divorced, or Separated**--If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The Plan of the Custodial Parent.
      - The Plan of the spouse of the Custodial Parent.
      - The Plan of the noncustodial parent.
      - The Plan of the spouse of the noncustodial parent.
3. **Active vs. Inactive Employee**--The Plan that covers a person as an employee who is neither laid off nor retired (or his or her dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

   If the other plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D (1) above.
4. **COBRA Continuation Coverage**--If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage**--If the preceding rules do not determine the order or payment, the Plan that covers the Subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
   a. **Two Plans Treated As One**--To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the covered person was eligible under the second within twenty-four hours after the first ended.
   b. **New Plan Does Not Include**--The start of a new Plan does not include:
      (i) A change in the amount or scope of a Plan's benefits.
      (ii) A change in the entity that pays, provides or administers the Plan's benefits.
      (iii) A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).
   c. **Measurement of Time Covered**--The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group Plan,

the date the person first became a Member of the Group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

6. **Equal Sharing**--If none of the preceding rules determines the primary plan, the Allowable Expenses shall be shared equally between the plans.

Effect on the Benefits of This Plan

A. **Secondary Plan Reduces Benefits**--When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total Allowable Expenses.

B. **Coverage by Two Closed Panel Plans**--If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the person's having received services from a non-panel provider, benefits are not covered by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

But, if services received from a non-panel provider are due to an emergency and would be covered by both Plans, then both Plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

Health Net may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Health Net need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give Health Net any facts it needs to apply those rules and determine benefits payable.

Health Net's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid, or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

"Amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Government Coverage

Medicare Coordination of Benefits (COB)

When you reach age 65, you may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Member enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If you are enrolled in Medicare Parts A and Part B, and are not an active employee or your employer group has less than twenty employees, then this Plan coordinate with Medicare and will be the secondary plan. . This Plan also coordinates with Medicare if you are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules . (If you are not enrolled in Medicare Part A and Part B, Health Net will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not

received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the Covered Services described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net. as required under this *Evidence of Coverage*

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare Coordination of benefits, unless you are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or

Write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare and Medicaid Services
6325 Security Blvd.
Baltimore, MD 21207

Medi-Cal

Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration

Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers' Compensation

This Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers' Compensation laws.

If you require covered services or supplies, and the injury or illness is work-related and benefits are available as a requirement of any Workers' Compensation or Occupational Disease Law, your Physician Group will provide services, and Health Net will then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

8. MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of contracting Physician Groups. Your Physician Group performs or authorizes all care, and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Customer Contact Center at the telephone number shown on your Health Net ID Card to obtain claim forms.

If you need to file a claim for emergency services or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

If you need to file a claim for outpatient Prescription Drugs, please send a completed Prescription Drug claim form to:

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call Health Net Customer Contact Center at **1-800-539-4072** or visit our website at www.healthnet.com/uc to obtain a Prescription Drug claim form.

If you need to file a claim for Emergency Chiropractic Services or Emergency Acupuncture Services or for other covered Chiropractic Services or covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with ASH Plans within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
Attention: Customer Contact Center
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Chiropractic Services or covered Acupuncture Services, you may call ASH Plans at **1-800-678-9133** or you may write ASH Plans at the address given immediately above.

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

Circumstances beyond Health Net's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant contracting Physician Group personnel, or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgently Needed Care" section under "Introduction to Health Net" Section 2.

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. The *Evidence of Coverage*, however, will be posted electronically on Health Net's website at www.healthnet.com/uc. The Group can opt for the Subscribers to receive the *Evidence of Coverage* online. By registering and logging on to Health Net's website, Subscribers can access, download and print the *Evidence of Coverage*, or can choose to receive it by U.S. mail, in which case Health Net will mail the *Evidence of Coverage* to each Subscriber's address on record.

If the Subscriber or the Group is required to provide notice, the notice should be mailed to the Health Net office at the address listed on the back cover of this *Evidence of Coverage* Confidentiality of Medical Records.

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free phone number on the back of your ID card** or contact Health Net at **1-800-539-4072.**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. This will include, but may not be limited to updating the Notice on our web site. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use And Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

  Person(s) Involved in Your Care or Payment for Your Care. We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

***This Notice of Privacy Practices also applies to enrollees in any of the following:** Health Net of Arizona, Inc., Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Other Uses or Disclosures that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request your written authorization to use or disclose your protected health information for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.
- **Psychotherapy Notes** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

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Your Rights Regarding Your Protected Health Information
You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information contained in a designated record set, with some limited exceptions. You may request that we provide copies of this protected health information in a format other than photocopies, such as providing them to you electronically, if it is readily producible in such form and format. Usually the protected health information contained in a designated record set includes enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of this protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing or sending electronically your requested information, but we will tell you the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

***This Notice of Privacy Practices also applies to enrollees in any of the following:** Health Net of Arizona, Inc., Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

Health Information Security
Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to This Notice
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com/uc. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Privacy Complaints
If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the next section.

We support your right to protect the privacy of your protected health information. We will not retaliate against you *or penalize you for filing a complaint.*

Contact the Plan
If you have any questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address: **Health Net Privacy Office**
Attention: Privacy Officer
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: **1-800-539-4072**
Fax: **1-818-676-8981**
Email: **Privacy@healthnet.com**

***This Notice of Privacy Practices also applies to enrollees in any of the following:** Health Net of Arizona, Inc., Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

9. DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Neuromusculoskeletal Disorders, Nausea and Pain. Acupuncture Services include services rendered by an acupuncturist for the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. Acupuncture Services do not include any other services, including, without limitation, services for treatment of asthma or addiction (including, but not limited to, smoking cessation).

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the Acute Condition.

American Specialty Health Plans of California, Inc. (ASH Plans) is a specialized health care service plan contracting with Health Net to arrange the delivery of Chiropractic and Acupuncture Services through a network of Contracted Chiropractors and Contracted Acupuncturist.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national Database used by Health Net.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Chiropractic Appliances are support type devices prescribed by a Contracted Chiropractor specifically for the treatment of a Neuromusculoskeletal Disorder. The devices this Plan covers are limited to elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar supports, lumbar cushions, Orthotics, wrist supports, rib belts, and home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic Services are chiropractic manipulation services provided by a Contracted Chiropractor (or in case of Emergency Services, by a non-Contracted Chiropractor) for treatment or diagnosis of Neuromusculoskeletal Disorders and Pain syndromes. These services are limited to the management of Neuromusculoskeletal Disorders and Pain syndromes primarily through chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. This includes: (1) differential diagnostic examinations and related diagnostic X-rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; (2) the follow-up office visits which during the course of treatment must include the provision of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Commercial Formulary is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com/uc. The Commercial Formulary is also referred to as "Recommended Drug List". Some Drugs in the Commercial Formulary require Prior Authorization from Health Net in order to be covered.

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Acupuncture services to Members.

Contracted Chiropractor means a chiropractor who is duly licensed to practice chiropractic in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Chiropractic services to Members.

Copayment is a fee charged to you for covered services when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 3.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Defined Disease is any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis are known.

Domestic Partner is, for the purposes of this *Evidence of Coverage*, the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the Subscriber's registered domestic partner who meets all the requirements of Sections 297 or 299.2 of the California Family Code. Your Group allows enrollment of same-sex and opposite-sex domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, so the term "Domestic Partner" also includes your domestic partner who meets your Group's eligibility requirements.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date on which the Employee or Family Member becomes covered or entitled to benefits under this Evidence of Coverage. Call your local Payroll or Benefits Office to confirm your Effective Date. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the plan.

Emergency Acupuncture Services are covered services that are Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system, or causing Pain or Nausea which manifests itself by acute symptoms or sufficient severity such that aperson could reasonably expect that a delay of immediate Acupuncture Services could result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

- **Emergency Care** includes medical screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and

surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency Care will also include additional screening, examination, and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate, the Psychiatric Emergency Medical Condition, either within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute Hospital or to an acute psychiatric Hospital as Medically Necessary.

Emergency Care includes air and ground ambulance and ambulance transport services provided through the **"911"** emergency response system.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request Independent Medical Review of a Plan denial of coverage for Emergency Care.

Emergency Chiropractic Services are covered services that are Chiropractic Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain such thatperson could reasonably expect that a delay of immediate Chiropractic Services could result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency Medical Condition. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Member or unborn child.

Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions," Section 7, for additional information.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness, or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which Health Net has issued the UC Standardized Contract to provide the benefits of this Plan.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members, and provide benefits through approved health plans.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in his or her place of residence that is prescribed by the Member's attending Physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility exists when any of the following apply to a Member, when the Member or the Member's partner has not yet gone through menopause:

- The Physician has diagnosed a medical condition that prevents conception or live birth; or
- The Member has had coitus relations on a recurring basis for one year or more without use of contraception or other birth control methods which has not resulted in a pregnancy, or when a pregnancy did occur, a live birth was not achieved; or
- The Member has been unable to achieve conception after six cycles of artificial insemination.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net will decide whether a service or supply is Investigational.

With regard to Chiropractic Services and Acupuncture Services, "Investigational" services are chiropractic care or acupuncture care that is investigatory.

Tier 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary.

Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Commercial Formulary.

Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Level III in the Commercial Formulary, drugs indicated as "NF", if approved,or Drugs not listed in the Commercial Formulary.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

With regard to Chiropractic and Acupuncture Services, "Medically Necessary" services are Chiropractic and Acupuncture Services which are necessary, appropriate, safe, effective and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Subscriber or an enrolled Family Member.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

Neuromusculoskeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Open Enrollment Period is a period of time each Plan year, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or. Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change Physician Groups at this time. The University may hold Special Open Enrollment Periods in addition to the annual period in exceptional circumstances. For example: Financial insolvency of other carriers currently used by the University or loss of providers in the University's service areas.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Health Net.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in "Out-of-Pocket Maximum," Section 4.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Period of Initial Eligibility (PIE) is the period during which an Employee or Family Member may enroll without furnishing proof of insurability. The PIE begins the day the Employee or Family Member becomes eligible and ends 31 calendar days from the first date of eligibility (or the preceding business day if the 31st day is on a weekend or a holiday).

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)". Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by the Group and described in the UC Standardized Contract and this *Evidence of Coverage*.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in "Schedule of Benefits and Copayments," Section 2, and "Covered Services and Supplies," Section 5. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- maintain good health
- prevent or lower the risk of diseases or illnesses
- detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" portion of "Covered Services and Supplies" for details regarding the prior authorization process relating to prescription drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist

or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Specialty Drugs are identified in the Health Net Commercial Formulary because they have at least one of the following features:

- Treatment of a chronic or complex disease
- Require high level of patient monitoring, or support
- Require specialty handling, administration, unique inventory storage, management and/or distribution
- Require specialized patient training
- Are subject to limited distribution

Specialty Drugs may be given orally, topically, by inhalation, or by self-injection (either subcutaneously, intramuscularly or intravenously). A list of Specialty Drugs can be found in the Health Net Commercial Formulary on our website at healthnet.com/uc or by calling the Customer Contact Center telephone number listed on your Health Net ID card.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this *Evidence of Coverage*. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of his or her family who meet the eligibility requirements of the Group and Health Net

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a Terminal Illness.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

UC Standardized Contract is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Urgently Needed Care includes otherwise covered medical service person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

NOTICE OF LANGUAGE SERVICES

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711). If you bought coverage through the California marketplace call 1-888-926-4988 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية أو اتصل على مركز الاتصال التجاري في 1-800-522-0088 (TTY: 711). في حال قمت بشراء التغطية من سوق كاليفورنيا، اتصل على الرقم 1-888-926-4988 (TTY: 711) وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من شركة التأمين على الحياة Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc.، اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Եթե ապահովագրում եք գնել Կալիֆորնիայի շուկայական հրապարակի միջոցով, զանգահարեք 1-888-926-4988 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese
免費語言服務・您可使用口譯員・您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088（TTY：711）。如果您是透過加州健康保險交易市場購買承保，請致電 1-888-926-4988（TTY：711）。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi
बिना लागत वाली भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711) पर कॉल करें। यदि आपने कैलिफोर्निया मार्किट प्लेस के माध्यम से कवरेज खरीदा है तो 1-888-926-4988 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company पीपीओ PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc. के एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Kev pab, hu rau peb ntawm tus xov tooj teev nyob rau hauv koj daim ID card los yog hu rau 1-800-522-0088 (TTY: 711). Yog tias koj yuav kev pov hwm ntawm California marketplace hu 1-888-926-4988 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088、(TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイス（保険購入サイト）を通じて保険を購入された方は、1-888-926-4988 (TTY: 711) までお電話ください。さらに援助が必要な場合：Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាកាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ដាល់មាត់។ អ្នកអាចស្ដាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បើសិនអ្នកបានទិញការធានារ៉ាប់រងតាមរយៈ ទីផ្សារនៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទូរសព្ទទៅលេខ 1-888-926-4988 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO ពីក្រុមហ៊ុនធានារ៉ាប់រងជីវិត Health Net Life Insurance Company សូមទាក់ទងទៅនាយកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net of California, Inc. នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나1-800-522-0088 (TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스를 통해 보험을 구입하셨으면 1-888-926-4988 (TTY: 711)번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' haine'igíí hóló. T'áá hó hazaad k'ehji naaltsoos hach'į' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néiho'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áaji' hodíilnih éí doodaii' 1-800-522-0088 (TTY: 711). California marketplace hoolyéhíjí béeso ách'áąáh naaniii ats'íís baa áháyą binilyé nahínínii'go éí koji' hóine' 1-888-926-4988 (TTY: 711). Shíká anáá'doowoł jinízingo: PPO éí doodaii' EPOqjí Health Net Life Insurance Company wolyéhíjí béeso ách'áąáh naa'nii binilyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'į' hojiinih 1-800-927-4357. HMO éí doodaii' HSPqjí Health Net of California, Inc.qjí béeso ách'áąáh naa'nii binilyé hats'íís bik'é'ésti'go éí koji' hojiinih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند.
برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی
1-800-522-0088 (TTY: 711) تماس بگیرید. اگر پوشش بیمه را از طریق بازارگاه کالیفرنیا خریداری کردید با شماره
1-888-926-4988 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی
Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس
بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی
DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਮਾਰਕਿਟ ਪਲੇਸ ਦੇ ਰਾਹੀਂ ਬੀਮਾ ਕਵਰੇਜ਼ ਖਰੀਦੀ ਹੈ ਤਾਂ 1-888-926-4988 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੇ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика.
Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711). Если свою страховку вы приобрели на едином сайте по продаже медицинских страховок в штате Калифорния, звоните по телефону 1-888-926-4988 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance), телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания DMHC, телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Si adquirió la cobertura a través del mercado de California, llame al 1-888-926-4988 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711). Kung bumili kayo ng pagsakop sa pamamagitan ng California marketplace tawagan ang 1-888-926-4988 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์คิดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) หากคุณซื้อความคุ้มครองผ่านทาง California marketplace โทร 1-888-926-4988 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711). Nếu quý vị mua khoản bao trả thông qua thị trường California 1-888-926-4988 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.

NOTICE OF NONDISCRIMINATION

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 1-888-926-4988 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the numbers above and telling them you need help filing a grievance; Health Net Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online:

Health Net
P.O. Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Online: healthnet.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800–368–1019, (TDD: 1-800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

INDEX

Contact us

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
1-800-539-4072 or www.healthnet.com/uc

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired
1-800-995-0852

SERVICE LIST

Barkan v. Health Net of California, Inc., et al.
Case No.: BC711987

CT Corporation System 818 W. Seventh Street, Ninth Fl. Los Angeles, CA 90017	Registered Agent for Service of Process of: Health Net of California, Inc.; Health Net Life Insurance Company; Managed Health Network, Inc.; Health Net, Inc.; and Centene Corporation

CALLAHAN & BLAINE
A PROFESSIONAL CORPORATION
3 HUTTON CENTRE DRIVE, NINTH FLOOR
SANTA ANA, CALIFORNIA 92707
TELEPHONE: (714) 241-4444
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Daniel J. Callahan (Bar No. 91490)
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Richard T. Collins (Bar No. 166577)
Damon D. Eisenbrey (Bar No. 215927)
3 Hutton Centre Drive, Ninth Floor
Santa Ana, California 92707
Telephone: (714) 241-4444
Facsimile: (714) 241-4445

Attorneys for Plaintiff Ohad Barkan,
individually and on behalf of all others similarly situated

SUPERIOR COURT OF CALIFORNIA

COUNTY OF LOS ANGELES

OHAD BARKAN, individually and on behalf of all others similarly situated,

Plaintiff,

v.

HEALTH NET OF CALIFORNIA, INC., a California corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation; MANAGED HEALTH NETWORK, INC., a Delaware corporation; HEALTH NET, INC., a Delaware corporation; CENTENE CORPORATION, a Delaware corporation; and DOES 1 through 100, inclusive,

Defendants.

CASE NO. BC711987

Assigned to:
Hon. Kenneth Freeman
Dept. 14

NOTICE OF INITIAL STATUS CONFERENCE

Date: October 5, 2018
Time: 10:00 a.m.
Dept: 14

Complaint Filed: June 29, 2018
Trial Date: None Set

PLEASE TAKE NOTICE that the Court has set an Initial Status Conference for **October 6, 2018** at **10:00 a.m.**, in **Department 14** located in the Spring Street Courthouse, at United States District Court, at 312 N. Spring Street, Los Angeles, California 90012.

Attached to this Notice are the Court's Minute Order and Initial Status Conference Order.

Dated: July 17, 2018

CALLAHAN & BLAINE, APLC

By: _____

Daniel J. Callahan
Edward Susolik
Richard T. Collins
Damon D. Eisenbrey
Attorneys for Plaintiff Ohad Barkan, individually and on behalf of all others similarly situated

CALLAHAN & BLAINE
A PROFESSIONAL LAW CORPORATION
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SANTA ANA, CALIFORNIA 92707
TELEPHONE: (714) 241-4444
WWW.CALLAHAN-LAW.COM

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

DATE: 07/11/18			DEPT. SS14
HONORABLE KENNETH R. FREEMAN	JUDGE	R. ARRAIGA	DEPUTY CLERK
HONORABLE Add-On #1	JUDGE PRO TEM		ELECTRONIC RECORDING MONITOR
T. LEWIS, C.A.	Deputy Sheriff	NONE	Reporter

BC711987

Plaintiff Counsel

OHAD BARKAN

NO APPEARANCES

VS

Defendant Counsel

HEALTH NET OF CALIFORNIA INC ET

Complex- 7-11-2018

NATURE OF PROCEEDINGS:

COURT ORDER REGARDING NEWLY FILED CLASS ACTION

By this order, the Court determines this case to be Complex according to Rule 3.400 of the California Rules of Court. The Clerk's Office has randomly assigned this case to this department for all purposes.

By this order, the Court stays the case, except for service of the Summons and Complaint. The stay continues at least until the Initial Status Conference. Initial Status Conference is set for October 5, 2018, at 10:00 a.m., in this department. At least 10 days prior to the Initial Status Conference, counsel for all parties must discuss the issues set forth in the Initial Status Conference Order issued this date. The Initial Status Conference Order is to help the Court and the parties manage this complex case by developing an orderly schedule for briefing, discovery, and court hearings. The parties are informally encouraged to exchange documents and information as may be useful for case evaluation.

Responsive pleadings shall not be filed until further Order of the Court. Parties must file a Notice of Appearance in lieu of an Answer or other responsive pleading. The filing of a Notice of Appearance shall not constitute a waiver of any substantive or procedural challenge to the Complaint. Nothing in this order stays the time for filing an Affidavit of

MINUTES ENTERED
07/11/18
COUNTY CLERK

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

DATE: 07/11/18	DEPT. SS14
HONORABLE KENNETH R. FREEMAN JUDGE	R. ARRAIGA DEPUTY CLERK
HONORABLE JUDGE PRO TEM Add-On #1 T. LEWIS, C.A. Deputy Sheriff	ELECTRONIC RECORDING MONITOR NONE Reporter

BC711987

OHAD BARKAN
VS
HEALTH NET OF CALIFORNIA INC ET

Plaintiff Counsel: NO APPEARANCES

Defendant Counsel:

Complex- 7-11-2018

NATURE OF PROCEEDINGS:

Prejudice pursuant to Code of Civil Procedure Section 170.6.

Counsel are directed to access the following link for information on procedures in the Complex Litigation Program courtrooms:

http://www.lacourt.org/division/civil/CI0037.aspx

According to Government Code Section 70616 subdivisions (a) and (b), each party shall pay a fee of $1,000.00 to the Los Angeles Superior Court within 10 calendar days from this date.

The Plaintiff must serve a copy of this Minute Order and the attached Initial Status Conference Order on all parties forthwith and file a Proof of Service in this department within seven days of service.

CLERK'S CERTIFICATE OF MAILING

I, the below-named Executive Officer/Clerk of the above-entitled court, do hereby certify that I am not a party to the cause herein, and that on this date I served this Minute Order and the Initial Status Conference Order upon each party or counsel named below by placing the document for collection and mailing so as to cause it to be deposited in the United States mail

MINUTES ENTERED
07/11/18
COUNTY CLERK

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

DATE: 07/11/18			DEPT. SS14
HONORABLE KENNETH R. FREEMAN	JUDGE	R. ARRAIGA	DEPUTY CLERK
HONORABLE	JUDGE PRO TEM		ELECTRONIC RECORDING MONITOR
Add-On #1 T. LEWIS, C.A.	Deputy Sheriff	NONE	Reporter

BC711987

OHAD BARKAN
VS
HEALTH NET OF CALIFORNIA INC ET

Plaintiff Counsel: NO APPEARANCES

Defendant Counsel

Complex- 7-11-2018

NATURE OF PROCEEDINGS:

at the courthouse in Los Angeles, California, one copy of the original filed/entered herein in a separate sealed envelope to each address as shown below with the postage thereon fully prepaid, in accordance with standard court practices.

Dated: July 11, 2018

Sherri R. Carter, Executive Officer/Clerk

By: R. ARRAIGA, Deputy Clerk

Richard Collins
CALLAHAN & BLAINE, APLC
3 Hutton Center Drive, Ninth Floor
Santa Ana, CA 92707

MINUTES ENTERED
07/11/18
COUNTY CLERK

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

CENTRAL DISTRICT

OHAD BARKAN, et al.,
Plaintiff,
vs.
HEALTH NET OF CALIFORNIA, INC., et al.,
Defendants.

Case No. BC711987

INITIAL STATUS CONFERENCE ORDER (COMPLEX LITIGATION PROGRAM)

Case Assigned for All Purposes to Judge Kenneth R. Freeman

Department: 14
Date: October 5, 2018
Time: 10:00 a.m.

This case has been assigned for all purposes to Judge Kenneth R. Freeman in the Complex Litigation Program. An Initial Status Conference is set for **October 5, 2018, at 10:00 a.m., in Department 14** located in the **Spring Street Courthouse,** at United States District Court, at 312 N. Spring Street, Los Angeles, California 90012. Counsel for all the parties are ordered to attend.

The Court orders counsel to prepare for the Initial Status Conference by identifying and discussing the central legal and factual issues in the case. Counsel for plaintiff is ordered to initiate contact with counsel for defense to begin this process. Counsel then must negotiate and agree, as possible, on a case management plan. To this end, counsel must file a Joint Initial Status Conference Class Action Response Statement ten (10) court days (**September 21, 2018 and provide a conformed courtesy copy DIRECTLY in Department 14)** before the Initial Status

Conference. The Joint Response Statement must be filed on line-numbered pleading paper and must specifically answer each of the below-numbered questions. Do not the use the Judicial Council Form CM-110 (Case Management Statement) for this purpose.

1. PARTIES AND COUNSEL: Please list all presently-named class representatives and presently-named defendants, together with all counsel of record, including counsel's contact and email information.

2. POTENTIAL ADDITIONAL PARTIES: Does any plaintiff presently intend to add more class representatives? If so, and if known, by what date and by what name? Does any plaintiff presently intend to name more defendants? If so, and if known, by what date and by what name? Does any appearing defendant presently intend to file a cross-complaint? If so, who will be named.

3. IMPROPERLY NAMED DEFENDANT(S): If the complaint names the wrong person or entity, please explain.

4. ADEQUACY OF PROPOSED CLASS REPRESENTATIVE(S): If any party believes one or more named plaintiffs might not be an adequate class representative, please explain. No prejudice will attach to these responses.

5. ESTIMATED CLASS SIZE: Please discuss and indicate the estimated class size.

6. OTHER ACTIONS WITH OVERLAPPING CLASS DEFINITIONS: Please list other cases with overlapping class definitions. Please identify the court, the short caption title, the docket number, and the case status.

7. POTENTIALLY RELEVANT ARBITRATION AND/OR CLASS ACTION WAIVER CLAUSES: Please include a sample of any clause of this sort. Opposing parties must summarize their views on this issue.

8. POTENTIAL EARLY CRUCIAL MOTIONS: Opposing counsel are to identify and

describe the significant core issues in the case. Counsel then are to identify efficient ways to resolve those issues. The vehicles include:

- Early motions in limine,
- Early motions about particular jury instructions,
- Demurrers,
- Motions to strike,
- Motions for judgment on the pleadings, and
- Motions for summary judgment and summary adjudication.

9. CLASS CONTACT INFORMATION: Does plaintiff need class contact information from the defendant's records? If so, do the parties consent to an "opt-out" notice process (as approved in *Belaire-West Landscape, Inc. v. Superior Court* (2007) 149 Cal.App.4th 554, 561) to precede defense delivery of this information to plaintiff's counsel? If the parties agree on the notice process, who should pay for it? Should there be a third-party administrator?

10. PROTECTIVE ORDERS: Parties considering an order to protect confidential information from general disclosure should begin with the model protective orders found on the Los Angeles Superior Court Website under "Civil Tools for Litigators."

11. DISCOVERY: Please discuss discovery. Do the parties agree on a plan? If not, can the parties negotiate a compromise? At minimum, please summarize each side's views on discovery. The Court generally allows discovery on matters relevant to class certification, which (depending on circumstances) may include factual issues also touching the merits. The Court generally does not permit extensive or expensive discovery relevant only to the merits (for example, detailed damages discovery) unless a persuasive showing establishes early need. If any party seeks discovery from absent class members, please estimate how many, and also state the

kind of discovery you propose[1].

12. INSURANCE COVERAGE: Please state if there is insurance for indemnity or reimbursement.

13. ALTERNATIVE DISPUTE RESOLUTION: Please discuss ADR and state each party's position about it. If pertinent, how can the Court help identify the correct neutral and prepare the case for a successful settlement negotiation?

14. TIMELINE FOR CASE MANAGEMENT: Please recommend dates and times for the following:

- The next status conference,
- A schedule for alternative dispute resolution, if it is relevant,
- A filing deadline for the motion for class certification, and
- Filing deadlines and descriptions for other anticipated non-discovery motions.

15. ELECTRONIC SERVICE OF PAPERS: For efficiency the complex program requires the parties in every new case to use a third-party cloud service. While the parties are free to choose one of the services shown below, this Court (Department 310) prefers that the parties select:

- **Case Anywhere (http://www.caseanywhere.com).**

The parties are not required to select Case Anywhere, but may chose instead either

- File & Serve Xpress (https://secure.fileandservexpress.com) or
- CaseHomePage (http://www.casehomepage.com).

Please agree on one and submit the parties' choice when filing the Joint Initial Status Conference Class Action Response Statement. If there is agreement, please identify the vendor. If

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[1] See California Rule of Court, Rule 3.768.

parties cannot agree, the Court will select the vendor at the Initial Status Conference. Electronic service is not the same as electronic filing. Only traditional methods of filing by physical delivery of original papers or by fax filing are presently acceptable.

Reminder When Seeking To Dismiss Or To Obtain Settlement Approval:

"A dismissal of an entire class action, or of any party or cause of action in a class action, requires Court approval . . . Requests for dismissal must be accompanied by a declaration setting forth the facts on which the party relies. The declaration must clearly state whether consideration, direct or indirect, is being given for the dismissal and must describe the consideration in detail."[2] If the parties have settled the class action, that too will require judicial approval based on a noticed motion (although it may be possible to shorten time by consent for good cause shown).

Pending further order of this Court, and except as otherwise provided in this Initial Status Conference Order, these proceedings are stayed in their entirety. This stay shall preclude the filing of any answer, demurrer, motion to strike, or motions challenging the jurisdiction of the Court. However, any defendant may file a Notice of Appearance for purposes of identification of counsel and preparation of a service list. The filing of such a Notice of Appearance shall be without prejudice to any challenge to the jurisdiction of the Court, substantive or procedural challenges to the Complaint, without prejudice to any affirmative defense, and without prejudice to the filing of any cross-complaint in this action. This stay is issued to assist the Court and the parties in managing this "complex" case through the development of an orderly schedule for briefing and hearings on procedural and substantive challenges to the complaint and other issues that may assist in the orderly management of these cases. This stay shall not preclude the parties from informally exchanging documents that may assist in their initial evaluation of the issues

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[2] California Rule of Court, Rule 3.770(a)

presented in this case, however shall stay all outstanding discovery requests.

Plaintiff's counsel is directed to serve a copy of this Initial Status Conference Order on counsel for all parties, or if counsel has not been identified, on all parties, within five (5) days of service of this order. If any defendant has not been served in this action, service is to be completed within twenty (20) days of the date of this order.

Dated: July 11, 2018

KENNETH R. FREEMAN

Judge Kenneth R. Freeman

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PROOF OF SERVICE

(CODE CIV. PROC. § 1013A(3))

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the County of Orange, State of California. I am over the age of 18 years and am not a party to the within action; my business address is **3 Hutton Centre Drive, Ninth Floor, Santa Ana, California 92707**.

On July 18, 2018, I served the following document(s) described as

NOTICE OF INITIAL STATUS CONFERENCE

on the interested parties in this action by placing: ☐ the original ☐ a true copy thereof enclosed in a sealed envelope addressed as follows:

Please see attached "Service List."

☒ **BY MAIL:** I deposited such envelope in the mail in Santa Ana, California. The envelope was mailed with postage thereon fully prepaid. I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. It is deposited with the United States Postal Service on that same day in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than one (1) day after date of deposit for mailing in affidavit.

☐ **BY PERSONAL SERVICE:** I caused such envelope to be hand delivered by Nationwide Legal to the addressees below.

☐ **BY FEDERAL EXPRESS:** I deposited such envelopes in Santa Ana, California for collection and delivery by Federal Express with delivery fees paid or provided for in accordance with ordinary business practices. I am "readily familiar" with the firm's practice of collection and processing packages for overnight delivery by Federal Express. They are deposited with a facility regularly maintained by Federal Express for receipt on the same day in the ordinary course of business.

☐ **BY FAX TRANSMISSION:** I transmitted the foregoing document by facsimile to the party(s) identified above by using the facsimile number(s) indicated. Said transmission(s) were verified as complete and without error.

☐ **BY EMAIL:** I transmitted the foregoing documents by electronic mail to the party(s) identified on the attached service list by using the electronic mail as indicated. Said electronic mail was verified as complete and without error.

I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made. I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct.

Executed on July 18, 2018, in Santa Ana, California.

Jeannie Kirwin